DOCUMENT RESUME

ED 048 432 VT 006 695

TITLE	A Unit of Learning About Homemaker-Home Health Aide Service. Teacher's Source Book.
INSTITUTION	Council on Social Work Education, New York, N.Y.; National Council for Homemaker Services, New York, N.Y.
REPORT NO	68-340-75
PUB DATE	Jan 68
NOTE	146p.
AVAILABLE FROM	Council on Social Work Education, 345 East 46th Street, New York, N.Y. 10017 ($3.00)
EDRS PRICE	EDRS Price MF-$0.65 HC Not Available from EDRS.
DESCRIPTORS	Annotated Bibliographies, *Companions (Occupation), Educational Objectives, *Health Occupations Education, *Home Health Aides, Learning Activities, Resource Units, Service Occupations, Subprofessionals, *Teaching Guides, Teaching Methods, *Unit Plan

ABSTRACT

Prepared by an advisory committee composed of members of the National Council for Homemaker Services, the Council on Social Work Education, the National Study Service, and specialists in social work, this teaching unit has been compiled to aid teachers in helping students learn about the homemaker-home health aide service. Included in the unit are: (1) a description of the homemaker-home health aide service, (2) educational objectives, (3) suggested content outline, (4) teaching-learning methods and experiences, including 13 selected study articles along with illustrated materials and how to use them, (5) major sources of information, and (6) an annotated bibliography. (SB)

TEACHER'S SOURCE BOOK

ED0 48432

A Unit of Learning about Homemaker-Home Health Aide Service

VT006695

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The Lois and Samuel Silberman Fund Project

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TEACHER'S SOURCE BOOK

A Unit of Learning about Homemaker-Home Health Aide Service

Suggested instructional materials for use in schools of social work, other professional schools, undergraduate courses and in-service training programs.

VT 006 695

Co-published by

Council on Social Work Education
345 East 46th St., New York, N. Y. 10017

National Council for Homemaker Services, Inc.
1740 Broadway, New York, N. Y. 10019

A UNIT OF LEARNING ABOUT HOMEMAKER-HOME HEALTH AIDE SERVICE

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FOREWORD

This material has been compiled to aid the teachers in helping students learn about homemaker-home health aide service. It is in the form of a teaching outline or "unit of learning" with suggested content, teaching media, illustrative materials, and a selected annotated bibliography. Some articles and unpublished papers of particular interest (not otherwise obtainable) are reproduced and included in this compilation.

Homemaker-home health aide service has been known for years under various names and under a variety of auspices as an emergency service, as well as a sustaining one, for individuals and families in periods of crisis. Originally a child welfare service, it now helps the chronically ill, disabled, and aged, as well as families, who require many different kinds of assistance with their daily living problems. Increasingly it is coming to be recognized as one of the most essential of all services designed to protect and restore individual and family functioning. It aids in preventing deterioration and progressive worsening of social and health problems. It serves as a preventive to the placement of children and adults away from their own homes. It assists in various protective functions. Often the homemaker-home health aide plays a large part in the rehabilitation process within a family and in helping an individual who has experienced a physical, mental or emotional problem to reach an optimum goal in functioning. Of major importance in helping families is the homemaker-home health aide who assists the family members in improving their levels of living.

The National Council for Homemaker Services believes it to be vitally important that all students preparing for professional practice in the fields of social welfare and health should be knowledgeable about this essential service. An understanding of its value to the community as a whole as well as to individuals and families will come about only through integrated knowledge of this specialized activity in relation to other community-based health and social services.

The Council on Social Work Education has agreed to co-publish this Source Book on Homemaker-Home Health Aid service as part of its series of teaching materials Publication, distribution, and promotion of these teaching materials by the Council on Social Work Education will help to bring them to the attention of both current and future personnel in a wide variety of welfare and health services. This Source Book is suggested for the use of graduate professional schools of social work and universities and colleges that offer undergraduate programs with social welfare content. It will be useful also in professional schools of public health, collegiate schools of nursing, departments of home economics, and for staff development programs of public or voluntary health and welfare agencies. It is designed to give a broad knowledge of homemaker-home health service. Materials are directed toward developing a knowledge about, and an understanding of, the service rather than developing technical or professional skill in rendering it.

Preparation of these teaching materials was undertaken by an advisory committee with the assistance of National Study Service. Committee members and the project writer represented health and welfare agencies with special knowledge about homemaker-home health aide service and teaching methodology.

The National Council for Homemaker Services expresses its gratitude to the Lois and Samuel Silberman Fund for its generous grant which made this Source Book possible. It also expresses its appreciation to the agencies, publishers and authors of the various materials who have given permission for the reproductions it contains. The Council acknowledges gratefully the contributions of the members of the advisory committee, and members and friends of the Council, who donated their time and their talents to assist in producing this valuable teaching-learning unit.

Betty Trippe

Mrs. Juan T. Trippe, President
National Council of Homemaker Services

January, 1968

INTRODUCTORY STATEMENT

Homemaker-home health aide service is one of the most rapidly developing specialized services in the fields of social welfare and health. It has been in existence in scattered localities in the United States since 1903 and as an organized service since 1923. The most spectacular growth of this service in Europe, Israel, the United States, and Canada has occurred since World War II, particularly during the 1960's, and is now spreading to to other countries, such as Japan, Australia, and New Zealand. Today homemaker-home health aide service is recognized as an essential ingredient of a community's health and social welfare services. It has received special impetus in recent years from the passage of broad social welfare and health legislation. Social insurance programs throughout Europe, Canada, and other countries as well as in the United States appear to assure further growth and expansion of this vital service. The service is expanding so rapidly that figures collected annually are out of date within a few months.

In recent years the character and concept of homemaker-home health aide service has altered. Formerly limited to a short-term emergency form of household help, it is now often provided on a longer-term basis. As a therapeutic, preventive, educational, protective, restorative, and rehabilitative service it is provided as a supplementary form of assistance when a social or health evaluation prescribes it for an individual or family. Objectives of the homemaker-home health aide service are in accord with those of the social or health agency or institution which prescribes it. The service is a part of the treatment plan, performing its functions in relation to and under the supervision of a professional staff member.

There are many unusual contributions which the homemaker-home health aid service provides along with the essential, practical, tangible household management functions. They include some intangibles in feeling and understanding, and every day "little things". These contributions need to be understood for maximum benefit of its use. A philosophy and a purpose underlie homemaker-home health aide service. The application of this philosophy is the responsibility of the agency which administers the service. The intake policy -- its priorities and its limitations -- is established on the basis of the agency's philosophy, its functions, and its resources. These need particular emphasis in interpreting what the service is which the agency has to offer. As is true of other specialized services, it is sometimes necessary to interpret its particular functions to the professional colleagues who may think they understand what it is and does, but who may expect too much or too little in planning for its use.

The service may exist as a division or branch facility of health and welfare agencies or institutions, public and voluntary, or as a separate agency whose sole function it is to provide this specialized service, sometimes on a community-wide basis. However, some large metropolitan areas are served by a number of homemaker agencies which, without duplication, are prepared to meet special needs. When the autonomous agency accepts applications for service from individuals, without referral from a health or welfare source, it is important that the request for service be evaluated by a professional staff member of the agency. This is essential to assure the validity of the request and the appropriateness of the use of the service within the preventive, protective, and rehabilitative goals of the independent agency. When people or agencies do not know that such a specialized service exists, they cannot turn to it for this kind of help. Also, as individuals or institutions, they will not support it without an understanding of its value.

Through the years different names have been applied to the individual who performs this practical, flexible service such as "substitute mothers", "visiting homemakers", "housekeeping aides", and "health aides". The term "homemaker-home health aide" is a generic term which evolved in the 1960's. It denotes a worker or aide whose function it is to assist professional health and welfare personnel in maintaining, safeguarding, or improving family life. Often the problems faced by individuals and families needing homemaker-home health aide service cannot be easily classified as solely "health", "welfare", "housekeeping", or "child care", but are interrelated, presenting more than one reason for this kind of help being provided. Experience has demonstrated that it is unnecessary, uneconomical, and impractical to have specialized personnel within a homemaker-home health aide service, with specific functions assigned to one group of employees who would be health-oriented and another group who would be welfare-oriented, one group to work with infants and children and another with the chronically ill and the aged. The homemaker-home health aide is trained to provide a variety of services, and the hyphenated term identifies that this service is a unified one. The aide is assigned as professional personnel are -- because of the priority need as well as the individual talents and strengths of the staff member. She or he (there are some men working as homemaker-home health aides) is increasingly a full-time, salaried staff member and a member of a team.

Leaders in the field of social welfare have stated that homemaker-home health aide service is "one of the most effective ways of counteracting the effects of poverty because it helps to safeguard, protect, stabilize and unify families, with its primary objective to preserve and strengthen family life. To accomplish this, however, the service must be conducted by an agency which can employ a sufficient number of homemakers to maintain continuity of service ... which assumes responsibility for the selection of competent homemakers, for the quality of service and for the soundness of fiscal and other administrative procedures".* It has been described as a "distinctively practical and down-to-earth service", "one for which there is no substitute", "an essential ingredient in preserving and strengthening family life", "an unique adjunct to casework", "an integral part of health care for patients in their own homes", and a service which has produced "individual miracles".

It was estimated in 1964 that 200,000 homemaker-home health aides would be required in the United States to serve the needs of families and individuals at that time. Presently it is estimated that approximately 10,000 homemaker-home health aides are employed full time or part time in the United States. Elsewhere the numbers are larger. In the United Kingdom, for example, with a population of about 55 million people, it has been estimated that 70,000 "home helps" are employed. Finland's recent legislation requires communities to provide one homemaker per 1,000 population.

There is still a long way to go in the United States before the service actually will be available to all the people who need it. Some of the agencies providing it today report that they are able to meet only one in five to one in twenty of the requests for the service. Some experts in social welfare are hoping that there will soon be as many homemakers attached to social agencies as there are social workers.

In summary, homemaker-home health aide service exists to maintain, strengthen, and safeguard family life. The nature of this service is preventive, protective, and rehabilitative. It is a straightforward, practical, flexible service, not just the provision of a housekeeper or a companion or a baby sitter. It is

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* Winston, Ellen, "Homemakers, A National Need". Paper given at the 1964 National Conference on Homemaker Services, Washington, D. C., April 29-May 1, 1964.

- an organized service, to meet the assessed needs of individuals and families
- provided on the basis of professional planning, under the supervision of professional welfare or health personnel
- offered under the auspices of community-based health and social agencies or institutions, public or voluntary
- selective of the individuals employed as the aides to provide service
- responsible for training this staff of full-time and part-time employees
- administratively responsible for working within the framework of the parent organization to which the service belongs or, when an independent agency, for working cooperatively with the other organized services within the framework of the total community health and welfare structure
- insistent that the home-maker health aide staff member serve as a member of a team
- active in interpreting its contributions, in evaluating its own services, and in improving its ways of working as new knowledge and new methods are evolved.

Teaching and Learning about the Homemaker-Home Health Aide Service

5

A UNIT OF LEARNING

EDUCATIONAL OBJECTIVES

Every student entering professional education in the fields of social welfare, health, home economics, and related areas which contribute to maintaining and strengthening individual functioning and family life should know what Homemaker-Home Health Aide Service is, how it functions, and when it can be used appropriately. It is equally important that students in pre-professional education should have general knowledge and information about the preventive, protective, and rehabilitative nature of homemaker services. Staff members of public and voluntary social welfare and health agencies will need particular information about the organized service programs in their communities, as well as general understanding of the nature of such services.

This unit of learning is designed to assist the teacher and the learner to achieve these objectives:

> Understand the nature of the service, its organizational structure, and its differential uses.
>
> Identify the common elements in homemaker-home health aide service under different auspices, which meet a variety of individual and family needs, and are utilized by other preventive, protective and rehabilitative services.
>
> Increase the awareness of homemaker-home health aide service as preventive, protective and rehabilitative in its own functions and in conjunction with or in contrast to alternative services and resources.

CONTENT

A. Purpose and function of homemaker-home health aide services

B. Principles and concepts of the service

C. Patterns of the service

D. Resource materials

TEACHING-LEARNING METHODS AND EXPERIENCES

A. Illustrative materials: brochures, pamphlets, case vignettes, critical incidents, problem-solving situations, case record material for class use.

B. Selected reading materials: reprints of selected papers and articles not readily accessible.

C. Other teaching media: annotated listing of audiovisual materials and action media.

D. Annotated bibliography.

E. Suggestions for additional source materials.

F. Some suggested learning experiences planned by the instructor with the appropriate agencies.

   1. Visit a training program of a homemaker-home health aide service.

2. Observe a staff meeting in an agency where cases are discussed for assignment of a homemaker-home health aide.

3. Prepare an audio tape of an interview with a homemaker-home health aide regarding her experience in serving families, and share with the class for discussion.

4. Read selected material from agency manual on homemaker-home health aide service and prepare outline as critique of the service.

G. Other suggested learning experiences.

1. Play one of the parts in a classroom reading of the play "To Temper the Wind", and participate in the discussion following.

2. Analyze assigned case record material in which homemaker-home health aide service was used.

3. Prepare analysis of the original development of an organized homemaker-home health aide service in the student's home community, to meet the special needs of a selected group of clients (such as the chronically ill, aged, families with handicapped children), or on a community-wide basis.

4. Read selected materials and lead class discussion on the use of homemaker-home health aide service in one or more settings (handicapped person, inadequate mother neglecting children, ill mother with young children, etc.).

5. Role-play selected situations in some aspects of homemaker-home health aide service to help students gain greater sensitivity to the feelings of a family, homemaker and professional staff members, social worker in team with health personnel and a homemaker, and other such groupings. Such a role-play may be taped for replay and further class discussion.

6. Use other teaching techniques such as "the rumor clinic", "the in-basket", problem-solving exercises or similar devices.

AGENCIES PROVIDING HOMEMAKER-HOME HEALTH AIDE SERVICE, AS OF JANUARY 1, 1968

By January, 1968, there was at least a beginning of homemaker service in every state, with a few states reporting substantial numbers of homemakers. However, the needs far outrun the supply in every state. This is highlighted by the ratios of homemakers to population. Also, the service needs will not be met until fully employed, salaried homemakers represent the dominant pattern in every state.

The facts reported in Table I and Table II were compiled by the National Council for Homemaker Services. Questionnaires were sent to 861 programs identified in the 1966-67 Directory of Homemaker-Home Health Aide Services of the National Council. Returns were received from 755 programs. Twenty-nine programs reported that, while they provide homemaker service, no homemakers were employed as of the reporting date, January 1, 1968.

The following programs which provide service through local units are tabulated herein as single programs, i.e., the local operating unit is not tabulated as a separate agency, but the operating facts of the activity of these local units are included in the figures: 6 District offices of the Illinois Department of Children and Family Services; 32 District offices in Kentucky, of the Department of Economic Security and of the Department of Child Welfare; 79 Municipal Public Welfare offices in Puerto Rico; 3 District offices of Catholic Charities of Westchester and Putnam Counties, N.Y.

TABLE I
Agencies Providing Homemaker-Home Health Aide Service, January 1, 1968, by Type and Auspice, by State

STATE	No. of Agencies Reporting by State (1)	Welfare (2)	Health (3)	Comb. H & W (4)	Public (5)	Voluntary (6)	Comb. Vol. & Pub. (7)
Alabama	2	–	2	–	1	1	–
Alaska	1	1	–	–	1	–	–
Arizona	6	5	1	–	2	4	–
Arkansas	6	6	–	–	2	4	–
California	29	18	11	–	13	16	–
Colorado	12	10	2	–	9	3	–
Connecticut	28	25	3	–	2	26	
Delaware	2	1	1	–	–	2	–
District of Columbia	1	1	–	–	–	1	–
Florida	7	6	1	–	1	6	–
Georgia	8	4	4	–	6	2	–
Hawaii	2	2	–	–	2	–	–
Idaho	1	–	1	–	1	–	–
Illinois	18	13	5	–	4	13	1
Indiana	22	9	13	–	10	12	–
Iowa	26	15	11	–	19	5	2
Kansas	2	2	–	–	–	2	–
Kentucky	5	3	2	–	3	2	–
Louisiana	7	5	2	–	5	2	–
Maine	7	6	1	–	–	7	–
Maryland	7	5	2	–	3	4	–
Massachusetts	27	19	6	2	4	22	1
Michigan	25	10	15	–	11	14	–
Minnesota	43	28	15	–	35	8	–
Mississippi	14	13	1	–	14	–	–
Missouri	12	9	3	–	4	8	–
Montana	14	14	–	–	14	–	–
Nebraska	3	2	1	–	1	1	1
Nevada	2	1	1	–	–	2	–
New Hampshire	1	1	–	–	–	1	–
New Jersey	23	21	2	–	–	22	1
New Mexico	3	2	1	–	3	–	–
New York	101	63	38	–	44	57	–
North Carolina	60	56	4	–	56	4	–
North Dakota	6	2	4	–	5	1	–
Ohio	53	24	29	–	27	22	4
Oklahoma	2	1	1	–	1	1	–
Oregon	7	6	1	–	6	1	–
Pennsylvania	37	25	11	1	5	28	4
Puerto Rico	2	1	1	–	2	–	–
Rhode Island	7	6	1	–	–	7	–
South Carolina	8	8	–	–	8	–	–
South Dakota	7	7	–	–	6	1	–
Tennessee	7	6	1	–	6	1	–
Texas	16	11	3	2	11	5	–
Utah	1	–	1	–	–	1	–
Vermont	1	–	1	–	–	1	–
Virginia	8	5	3	–	1	7	–
Washington	9	9	–	–	7	2	–
West Virginia	3	3	–	–	1	2	–
Wisconsin	48	42	6	–	41	7	–
Wyoming	6	3	3	–	6	0	–
TOTALS	755	535	215	5	403	338	14

SOURCE: National Council for Homemaker Services

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Table II

Agencies Providing Homemaker-Home Health Aide Service, January 1, 1968, by Number of Homemakers, Estimated Need, Time Employed, and Payment, by State,

STATE	No. H-HHA (1)	State Quota of Homemakers Based on 1960 Census Data (2)	Employed		Regular Salary (5)	Paid for Hours Worked (6)
			Full Time (3)	Part Time (4)		
Alabama	12	3,600	3	9	3	9
Alaska	10	200	1	9	1	9
Arizona	26	1,400	21	5	22	4
Arkansas	13	2,000	13	–	13	–
California	912	17,600	381	531	171	741
Colorado	88	2,000	65	23	27	61
Connecticut	514	2,800	189	325	90	424
Delaware	10	400	5	5	5	5
District of Columbia	99	800	14	85	14	85
Florida	297	5,600	4	293	6	291
Georgia	99	4,400	99	–	99	–
Hawaii	14	800	14	–	14	–
Idaho	6	800	–	6	–	6
Illinois	312	11,200	204	108	192	120
Indiana	138	5,200	77	61	75	63
Iowa	499	3,000	43	456	24	475
Kansas	18	2,400	2	16	2	16
Kentucky	57	3,400	46	11	46	11
Louisiana	18	3,600	9	9	9	9
Maine	43	1,000	14	29	13	30
Maryland	149	3,400	113	36	75	74
Massachusetts	487	5,800	155	325	70	417
Michigan	239	8,800	162	77	128	111
Minnesota	413	3,800	84	329	122	291
Mississippi	14	2,400	8	6	2	12
Missouri	157	4,800	148	9	136	21
Montana	28	800	10	18	11	17
Nebraska	9	1,600	6	3	6	3
Nevada	66	400	16	50	–	66
New Hampshire	8	600	8	–	8	–
New Jersey	1,448	6,800	225	1,223	3	1,445
New Mexico	9	1,000	5	4	–	9
New York	2,591	18,800	1,633	958	1,137	1,454
North Carolina	161	5,000	154	7	150	11
North Dakota	17	800	1	16	1	16
Ohio	507	10,800	414	93	170	337
Oklahoma	34	2,600	–	34	–	34
Oregon	43	2,000	29	14	29	14
Pennsylvania	762	13,600	302	460	246	516
Puerto Rico	527	2,600	445	82	445	82
Rhode Island	70	1,000	25	45	18	52
South Carolina	24	2,600	24	–	24	–
South Dakota	6	800	3	4	2	5
Tennessee	63	4,000	20	43	20	43
Texas	78	10,600	60	18	45	33
Utah	3	1,000	2	1	2	1
Vermont		Did not report				
Virginia	104	4,400	58	46	42	62
Washington	36	3,200	13	23	16	23
West Virginia	44	2,000	38	6	10	34
Wisconsin	135	4,400	96	39	87	48
Wyoming	12	400	7	5	3	9
TOTALS	11,429	203,400	5,468	5,962	3,834	7,596

SOURCE: National Council for Homemaker Services

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Selected Articles for Study

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I HOMEMAKER SERVICE IN THE UNITED STATES*

ELIZABETH WATKINS
Staff Associate
American Public Welfare Association

Before presenting the background of Homemaker Service in the United States it would be helpful, I think, briefly to refresh your knowledge of some of the mores and values of our society which have affected the development of Homemaker Service in this country. In the early decades of this nation, our pioneer families did not possess the same kinship family ties that they and their ancestors had known in Europe. Small segments of large families and single individuals were the early migrants to the United States, although the usual pattern was for other members of the family -- wives and small children, older parents and other close relatives, to be sent for as soon as the initial newcomer had settled down in a community and in a job.

Great value was placed upon independence and self-reliance in the individual, with inter-dependence among neighbors a characteristic of mutual helping methods of meeting catastrophic events. As our society evolved from a pioneering one of exploration and settlement into a stable agrarian order and then into industrial urbanism, each phase steadily increasing our national affluence, we paid increasing homage to the virtues of independence, self-sufficency,and material achievement.

Based, in part, upon our European legal and cultural heritage and molded by our environment our economic, political and social structures, certain forces and public attitudes have determined the nature of social welfare philalophy, programs, and practices in the United States. Among those which have significantly influenced the development of Homemaker Services are: the extended era of institutional programs for various types of dependent persons; the centuries old acceptance of the premise that the "poor are always with us" with the concomitant acceptance of acts of charity as religious and moral obligations; the prevalence of the assumption that poverty inevitably was associated with laziness, lack of initiative and a variety of undesirable personal, cultural and ethnic attributes; the widespread assumption, even in contemporary times, that social services are for the poor, the under privileged, the deprived in our society; the fears and concerns of citizens over the danger of "coddling the poor," which is an euphemism to justify restrictive regulations and inadequate grants in public assistance programs; the depression of the 30's; and the development of governmental welfare programs under the Social Security Act of the mid-thirties and the subsequent amendments thereto.

In the decades prior to World War I, two voluntary family welfare agencies employed visiting housekeepers to work with families whose need was based on the illness and consequent inability of the mother to take care of home and children.

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*This paper was given at the Seminar on Homemaker Service at the International Conference of Social Work, Washington, D. C., August 30, 1966.

The names of the agencies indicate the status of the families to whom help was given; i.e., The Family Service Bureau of the Association for the Improvement of the Conditions of the Poor, in New York City; and the Associated Charities of Detroit, Michigan. A few years after World War I (1923), the first organized homemaker program in the United States was initiated by the Jewish Welfare Society of Philadelphia, Pennsylvania to place motherly women as housekeepers in homes where the mothers were "temporarily incapacitated in order to avoid the placement of children in institutions and foster homes."*

During the 20's and early 30's, a gradual increase in homemaker programs occurred in the voluntary family and children's agencies.

The primary purpose of these early programs was to prevent foster home or institutional placement of children because of the incapacity or absence from the home of the mother. The depression years of the 30's saw the development of programs of housekeeping aides under a Federal program of the Works Progress Administration. Although the primary purpose of the Housekeeper Aide projects was to train and provide employment for needy women, the health and welfare agencies to whom these women were assigned made effective use of their training and skills to provide services to families with children, disabled or chronically ill, aged persons in their homes.

During the 40's and 50's there was a slow but steady increase in Homemaker Service programs, with the greater increase in voluntary Family and Child Welfare agencies. It is particularly important to note the sustained efforts of a small voluntary group, the National Committee on Homemaker Service, which was the immediate outgrowth of an informal conference convened by a Federal agency, the U. S. Children's Bureau, with participation by representatives of voluntary and public welfare and health agencies throughout the country. Members serving on the National Committee on Homemaker Service were representative of the helping professions, governmental and voluntary, national and local organizations, agencies and lay boards. The dedication and determination of this small group was undoubtedly the single most consistently sustaining force in actively promoting and encouraging the development of homemaker programs in a variety of agencies. I mention the composition of this committee because it represented the kind of coordinated effort and activity among different voluntary and governmental organizations, each with specific areas of function, but all with common concerns in the development and provision of homemaker service. This continues to be an important characteristic of the homemaker field in the United States.

At the level of the Federal government, funds to provide substantial support for homemaker programs are available through grants to the states by the Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services, Children's Bureau, through several programs under the United States Public Health Service, the Vocational Rehabilitation Administration.

Training programs are available through the Office of Education and the Manpower Development and Training Programs of the Department of Labor. State and local governmental units also provide funds for these services in state-wide or local programs. In addition to funding the homemaker programs, the Federal or state agencies provide consultation and assistance to both public and voluntary agencies.

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*Quoted from Homemaker Services--History and Bibliography. Maud Morlock. U.S. Department of Health, Education, and Welfare, Children's Bureau. 1964.

Homemaker programs in the voluntary field have continued to increase in family and child welfare agencies, in community nursing and health services, and in independent homemaker agencies. Wherever the new programs are established, or older programs expanded, you will find planning or advisory groups which represent a cross section of the community. Questions and decisions on auspices, financing, purpose, structure and administration involve lay and professional persons who are identified with community services, needs and resources.

On June 30, 1966, a total of 545 agencies in the United States and Canada were providing Homemaker Service. (I hope a few more have joined the ranks since June.) Of this number, 492 were in the United States; 227 were public agencies, 256 were under voluntary auspices and 9 were combined public and voluntary endeavors. These 492 programs are located in a wide variety of agencies. In the voluntary field, the largest number of homemaker service programs are in family and child welfare agencies, with independent homemaker agencies constituting the second largest group. Smaller numbers are located in visiting nurse associations and other health agencies. In the public field, by far the greatest number are in state and county welfare departments, with a relatively small number in health or other public agencies.

In spite of the high percentage of programs in certain types of agencies, it is interesting to note the range and variety of other auspices which include; a state hospital for the mentally ill; maternal and infant care projects under local boards of health; a special health project sponsored by the United Cerebral Palsy Association; a program under a local school Public Adjustment Program, and several hospital and clinic home care programs.

The geographic distribution of homemaker service is also wide. In the early years, services were concentrated in highly urban areas of the country. With the increase in services, there has been a wider distribution. The comparative growth is more rapid in the public field where most programs offer county-wide services, although some are on regional or state-wide bases.

Another significant change in recent years has been the trend toward more flexible and inclusive provision of service. Few, if any, agencies have rigid time limitations of service, either in terms of duration or the daily hours involved. Earlier arbitrary durational limits of certain maximum time factors, such as 60 or 90 days, or 8 hours per day, 5 days a week, have been changed to meet the realities of need. The duration of the service is determined by the continuing need for it, which in turn is determined by the continuing assessment of the professional worker, or team, and the family. This joint assessment also determines whether or not service is provided four, eight or twenty-four hours a day, the number of days a week, the nature of the service, of course, and any modifications required by changing circumstances.

Homemaker services, while expanding in the traditional areas of use; i.e., to provide care for children in their own homes and to assist and enable ill, disabled or aged persons to maintain themselves in their own homes, also are used in many new and exciting ways. In general, homemaker service augments and extends the wide range of social welfare and health services designed to maintain, improve or support the social and physical functioning of families and individuals in their homes and communities. Do not allow my reiteration of the phrase "in their own homes" to mislead you, for I use it in the sense of the place of abode of the individual or family to differentiate home from an institution or place of congregate living. In some communities homemaker service is provided for migrant farm labor families who move from state to state during the harvest season.

Homemakers are used in protective services, in teaching immature and inadequate mothers how to care for children and manage their homes, in some instances they assist in group sessions for homemaking and child care training activities for adolescent mothers and in assisting in special training, rehabilitative work with the disabled in post-hospital care, and in special projects with families of severely retarded or emotionally disturbed children. They may be assigned 24 hours a day in single parent home where the mother is hospitalized, or they may be assigned 2 or 3 hours daily or at intervals throughout the week to meet the needs of a solitary elderly householder. A homemaker may remain in the home a few days or for an indefinite period, according to the specific needs of the family.

Great impetus to the broadening scope of homemaker services was given by the enactment of Title XIX of the Social Security Act, which made support available for a wide range of health programs, including certain in-home services including homemaker-home health aide service. Still broader availability and utilization of these services are in the provisions of Title XVIII, more commonly known as the Medicare Act.

Under these major national health programs, specific coverage is provided for home-health aides. The Title is essentially descriptive of the function, and is not indicative of differences in the qualifications of the personnel. The similarities between homemakers and home health aides is clearly stated in the following excerpt from a statement issued by the Bureau of Family Services, Department of Health, Education, and Welfare:

> ".....personal care for the ill or disabled may be provided by homemakers and/or home health aides, provided proper standards and safeguards are maintained. These services are alike in the following ways:
>
> a. They enable ill or disabled persons to return to or remain in their own homes.
>
> b. They are carried out by mature women (sometimes men as home health aides) whose background and experience indicate their capacity to provide the needed personal care.
>
> c. The helpers are recruited, trained, assigned, and supervised by the professional staff of the agency which employs them.
>
> d. Their services are a part of a total service program, either health or social welfare or both. In other words, neither the homemaker nor the home health aide provides services alone but always as a part of a team effort, and under professional supervision."

The significant difference is:

> "The home health aide is used when there is a specific need for personal care and attendant-type service for an ill or disabled individual. It is a specific service and limited to persons under an active medical treatment plan."

With the Medicare program reaching approximately 19 million persons 65 years of age and over and the recognition in geriatric practice of the importance of home-care health programs for the aged, we may be certain that the expansion of Homemaker-Home Health Aide programs in the United States is still in the early stages.

Any rapidly expanding service seems to develop complexity in geometric progression and with its multiple sources of funds, the range of sponsorship and auspices, the intricate combinations of administrative, training and supervisory functions among agencies, homemaker-home health aide services may well run the gamut of inter-agency and inter-disciplinary complications. This could be an overwhelming thought, but it isn't really because there are balancing factors on the other side of the ledger. The pattern of cooperative, coordinated planning is well established. Cohesiveness, which was nurtured by the National Committee on Homemaker Service has characterized the field throughout its initial developmental stages. The young, vigorous and vitally important National Council for Homemaker Services is representative of the spirit and process of cohesion and coordination. Implicit and explicit in its role, function and its relationships with its members and the field of home-maker home health aide service are its responsibility for leadership in promotion, standard setting, interpretation, education and the essential coordination of the many and varied strands that constitute the fabric of our homemaker programs in the United States.

II HOMEMAKERS – A NATIONAL NEED*

ELLEN WINSTON, Ph.D.
Commissioner Welfare Administration
U.S. Department of Health, Education and Welfare

THE ACUTE and pressing need for expansion of homemaker service throughout the United States must be very clear to every member of this audience. You have heard graphic descriptions of the broad scope of our country's social and health needs. You have sensed at the meeting -- and I know you share -- an eagerness to help alleviate conditions which blight the social tapestry of the world's most affluent nation.

You share also the knowledge that problems confronting our citizens on the homefront are not in a great many cases the problems brought for solution to the legislative chambers or to the offices of administrators.

These problems come to your agencies, established to help deal with the human dilemmas of our highly complex society. Homemaker service is a distinctively practical and down-to-earth service; it faces and attempts to meet human need in the places where it most frequently occurs and where it can cause the most severe damage. That place is the home, and it is against the domestic backdrop that we plan for and develop our services.

We have declared war on poverty. Public and private agencies are marshaling their forces to win a decisive victory. The enemy is stark poverty, affecting at least a fifth of our Nation's population. By attacking the family, the cradle of our Nation's character and its basic social unit, poverty can and does contaminate the balance of our society.

Homemaker service is one of the most effective ways of counteracting the effects of poverty because it helps to safeguard, protect, stabilize and unify families, with its primary objective to preserve and strengthen family life.To accomplish this, however, the service must be conducted by an agency which can employ a sufficient number of homemakers to maintain continuity of service and which assumes responsibility for the selection of competent homemakers, for the quality of service and for the soundness of fiscal and other administrative procedures.

ORGANIZATION NEEDED

This is not a program that can be operated independently by any woman who is willing to go into a home and help out. Nor is it a program that can expect to operate at a profit, since many who need the service most can least afford to pay for it. The service must be multifaceted and versatile, geared to focus on many different areas of need -- helping children, inadequate mothers, the aged and chronically ill, the physically handicapped or emotionally disturbed. Perhaps its most significant hallmark in a society more depersonalized now than ever before is the deeply personal quality of its approach.

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* Paper given at the National Conference on Homemaker Services in Washington, D. C., on April 29, 1964. Reprints available U.S. Government Printing Office: 1964

We recognize that the chrome and glitter of an automation age affect not at all the anguish of a father who cannot earn enough money to feed his children or the despair of a teenage mother whose baby needs milk an improvident husband, not yet 20, cannot buy because he does not have the skills to qualify for a city job.

From poverty spring other symptoms of social maladjustment which call for immediate treatment to prevent their becoming incurable diseases. These symptoms run the gamut from teenage school dropouts to the child-battering syndrome evident among a shockingly large number of adults.

Though there are some who persist in refusing to look below the surface and thus to discover the real "whys" of poverty, we know there are causes which can be corrected. Unlike those who prefer to blame rather than to lend a constructive helping hand, we know with a frightening awareness that poverty is not a condition which stands in isolation separated from the comfortable middle class. Its effects touch everyone directly or indirectly.

Because this is true, the homemaker performs an urgent, vital mission for which she must tap her full energies and use all of her capacity for enterprise and imagination. When properly used, the homemaker can often help to prevent disaster. Time after time we find that the homemaker, by helping to improve the family's standard of living, has also relieved emotional problems which threatened to scar the children.

HOW THE HOMEMAKER HELPS

In a crisis, the separation of an individual from his family or from familiar surroundings can be a highly traumatic experience from which recovery is difficult. The disrupted home is not easily put back together. The need to pick up the shattered pieces may have severe repercussions for the children, for the parents, or for both. Homemaker aid prevents this.

Chronically ill and aged people are usually not adaptable to major change. The move from one place to another or a change in the immediate physical environment may disorient them, making them more dependent than ever; at the very least, it will be an upsetting experience. The homemaker steps in; she soothes and comforts, makes things bearable again.

She steps in, too, to give the foster mother a respite when, due to illness or some other crisis or special problem, she is temporarily unable to carry the responsibilities she agreed to assume when her home was accepted for the placement of children who needed foster care. These are only a few of the areas in which homemakers are providing effective services today.

GROWTH OF SERVICE

Despite the obvious value of homemaker service, its growth has been distressingly slow, although it has accelerated in recent years. A comparison of the statistics of 1958 and 1961 shows that the service expanded much more rapidly in this period than in any previous period since its inception. The total number of all agencies providing homemaker service increased by about 40 percent over that 3-year span.

Between 1961 and 1963 there were even greater increases, approximately 50 percent, in the number of homemaker agencies and homemakers employed, and an increase of 75 percent in the number of families served.

In 1963, 303 agencies administered homemaker programs in 44 States, the District of Columbia, and Puerto Rico. These agencies employed over 4,900 homemakers and cared for nearly 9,600 families in October 1963.

But in terms of need, as you well know, this is a bare beginning. Great Britain, with a population about a fourth as large as ours, has 55,000 homemakers and needs more. Also, the homemakers we do have are concentrated in a few areas. Almost a fifth of them -- 945 to be exact - are in New York City. The other 9 largest cities, with a combined population of about 14 million, are served by less than 500 homemakers, 200 of whom are in just 2 cities, Cleveland and Chicago. If every community is to have this service available for its growing number of elderly and chronically ill and for the vast number of children whose parents need help or guidance in creating a better home life for their children, we must enlist homemakers by the tens of thousands.

FEDERAL AID

Recent Federal legislation offers real hope that communities can now move forward rapidly to develop and expand homemaker programs. Through the Manpower Training and Development program, Federal aid is available to train homemakers and thus open a most satisfying professional career to older women whose own families are grown. Through the Community Health Services and Facilities Act, Federal funds can help to finance homemaker service as a part of the care at home that would prevent many elderly and chronically ill persons from having to enter hospitals and nursing homes and that would enable others to leave such institutions earlier.

Potentially, however, the greatest financial aid is available through a provision of the 1962 public welfare amendments to the Social Security Act which authorizes the Federal government to pay 75 percent of the cost of developing and expanding homemaker programs in public welfare agencies on a permanent basis. These programs need not be limited to persons who are currently dependent on public assistance but can serve other low income homes where homemakers are needed.

There are also two other ways in which Federal funds can be made available to public welfare agencies for homemaker service; namely, through the child welfare grant program administered by the Children's Bureau (32 States are now using some of these grants to provide or purchase homemaker service) and through demonstration grants available from both the Children's Bureau and the Bureau of Family Services.

DEMONSTRATIONS

The demonstration program of the Bureau of Family Services was authorized by the 1962 amendments. It makes Federal funds available for projects sponsored by public assistance agencies which contribute to the prevention of dependency, rehabilitate those who have become dependent, or improve the administration of public assistance agencies. Projects can be carried out cooperatively with voluntary agencies. Obviously, a project to demonstrate and evaluate the effectiveness of homemaker service in meeting these objectives would be an appropriate use of such funds. Various public assistance requirements, such as that the service be statewide, can be waived for these projects.

Research and demonstration funds are also available through the Children's Bureau which can be used in connection with homemaker services. These funds are available to either public or voluntary agencies. The projects must be of regional or national significance. Examples of such projects now being carried out with these funds are one demonstrating the use of homemaker service for the families of the mentally retarded child and another used for treatment and prevention of juvenile delinquency.

I would hope that first priority in the homemaker programs supported with welfare funds would be given to the area of service which is least well met at the present time; namely, the use of the homemaker as teacher and guide in the most deprived and poverty stricken homes. This calls for a person with special skills. She must also have considerable supportive help from casework staff. It is not enough that she instruct -- as a home economics teacher might do -- she must also motivate the desire to learn and improve, and this she can do only as she wins her place in the hearts of the families she serves so that they come to share her standards and strive to meet them.

PROGRAM GUIDELINES

To interest the type of women who can perform this difficult task, the position must be given real status. But such status must come from the recognition given to those who perform a much needed human service rather than from building into the position many standardized professional qualifications and requirements.

Programs must be kept simple, economical, and flexible. I want to underscore this. If families can get homemakers only at certain hours, if the homemaker's duties are spelled out too rigidly, if qualifications bar many warm, motherly women who can do the job even though their formal education may be limited -- then this service will fail in its highest purpose. While safeguards must be established to prevent exploitation of the homemaker, it is equally important that arrangements be made so that there is weekend and night service when it is needed and that great reliance be placed on the judgment of the homemaker as to what tasks she will perform. She must be allowed flexibility to adjust her services to individual needs since no two cases are exactly the same. To highlight how varied their situations are let us consider some of them.

EXAMPLES OF SERVICE

With the increase in young marriages, many extremely immature parents are struggling to establish homes on inadequate incomes and to learn infant care and budget management. A homemaker as a teacher for such a family can often make the difference between a broken home and a reasonably stable environment for children.

Homemaker service as a teaching tool which became also a needed preventive can be seen in the following example:

According to school officials and neighbors, conditions in the Brown home were so bad that the seven children should be removed. A juvenile court worker, sent to interview the mother, could not fail to notice the love and affection shared by parents and the youngsters. Homemaker service on a teaching basis was requested, though there was some doubt as to whether even a homemaker could improve the deplorable home conditions.

When she first visited the home, the homemaker found almost impossible chaos. There were dogs, cats, and chickens eating from the table. The 12-year-old was patting out cookie dough on the floor. Clothes and junk were piled in the corners. The parents were uneducated and had never been exposed to good housekeeping standards. But they were open to suggestions for improvement of the home. In a fairly short time the homemaker, in cooperation with the caseworker and with other help from the agency that employed them both, had brought about a change in the whole atmosphere of the home. Some of the more tangible evidence of this was that the family had moved the animals outdoors, hung up their clothes, scrubbed the house, and tidied up the premises. The neighbors telephoned to commend the obvious improvements which took place after "that homemaker lady" had come.

There are numerous instances of parents who are unable to use small incomes wisely to manage a household, but who do have a genuine affection for their children. We recognize there is no adequate substitute for a parent's love to be found in any foster care institution. With homemakers to help raise home standards, fewer children would need to be placed among strangers.

Homemaker service is also needed to help young mothers with new babies, particularly those in low income groups, who are often discharged from hospitals within 24 to 48 hours after the child is delivered. Homemaker service, when available, is an important service to this increasing number of families, many of whom have to cope with inadequate housing and poor equipment, and have very little knowledge about good infant care.

Increasingly, homemaker service is likewise being used in families where the mother is in the home, but because of a chronic illness, such as heart disease, tuberculosis, or arthritis, is not able to carry on her duties fully. Under such circumstances, the homemaker does not usurp the role of the mother but supplements her and makes certain that she retains as much responsibility as possible. Continuing supervision and evaluation by the professional workers in the agency are the keys to success in a situation of this kind.

Sometimes agencies have placed a homemaker with the same family for several years. In motherless homes, long-term service is especially important. Fathers left alone to rear a family usually cannot carry a job and manage children and a household. Homemaker service during the day supplements the father's efforts and yet makes it possible for him to retain his responsibilities for his family.

At first glance, provision of theservice on a long-term basis--such as these families require--may seem to be an undertaking which is far too expensive. But a closer look shows us that children placed in a foster home or in an institution often remain public charges for many years. The average expenditure for homemaker services for a family of children is considerably less than that of foster care.

Homemaker service is also needed by the growing number of families who are moving into cities from rural areas. They are confronted by a maze of bewildering modern conveniences which we take for granted as a part of daily living. They must meet new and demanding schedules, adapt to unfamiliar jobs, grow accustomed to city crowds and traffic and even talk a language different from what they spoke before.

RELATION TO DAY CARE PROGRAMS

Another growing area of need for homemaker service is in the homes of working mothers. Nine million children under 12 have mothers who work and the number is increasing rapidly. Most of these mothers work because they must supplement their husband's income or because they are the family's only wage earner. Day care programs are the answer to the needs of many of the children of working mothers and, with Federal funds now available, we hope to see a sharp rise in licensed facilities that can give children the care they need at fees parents can afford.

But the very existence of day care programs also increases the need for homemaker service to care for these children when they are ill. Neither day care homes nor day care centers can take care of sick children, nor will employers hire women who are going to be absent whenever a child is ill.

I am glad to say there is increasing collaboration among public and voluntary agencies in developing homemaker services. In some places, especially in some of the smaller communities, it may be found advantageous to have one homemaker service which serves all of the health and welfare programs. In other areas, where there is large concentration of problems, it may be more advantageous to develop a homemaker service in each of the service agencies. The important thing is to see that we get more services by expanding both the public and the voluntary programs.

ECONOMIC ASPECTS

Just as poverty is not an isolated condition, so the various facets of homemaker service are not best used if regarded as service isolated from other kinds of help provided to individuals and families who are in need. Homemaker service has become entwined now as a part of the Nation's social welfare fabric. In the realm of human need there is almost no area beyond its reach.

It is a first line of defense for parents and children and old people against family breakdown. It helps to prevent serious emotional disturbances that may follow separation. It maintains and builds family strengths in both young and elderly families. Schools find that homemaker service means better care and regular attendance of children from families lacking the care of a mother or from families where the mother had little in the way of homemaking skills. Industries increasingly see in homemaker service a way of reducing absenteeism.

It is sound economy to provide a service that makes unnecessary the removal of children from their own homes and their maintenance in foster homes or institutions. It is sound economy to provide a service that reduces the time patients must spend in hospitals or elderly persons must be cared for in nursing homes. It sound economy to bring intelligent and capable women into the homes of the deprived to help them raise their levels of living and thus move toward breaking the cycle of poverty.

On a dollar and cents basis alone, no community can afford to be without adequate homemaker services. Yet even more compelling reasons why these programs must grow, and grow rapidly, are the human reasons. You know the help homemakers can bring to people in all walks of life. You know there is no financial or other reason why anyone who needs this service should lack it. And therefore, all of us through our agencies and with the cooperation of this new Council for Homemaker Services have the power to bring homemaker programs up to the full strength this Nation needs. When we meet again, let us hope to meet as representatives of many thousands of homemakers, contributing their vital services in every community throughout our land.

III A HOMEMAKER SPEAKS*

NORMA LEEDAHL
Homemaker

I first learned about the homemaker job from an ad in the paper and also over the radio from the employment agency. I inquired about the job and talked with the county welfare director, who encouraged me to apply. I was very interested as I heard how I could be of some help to families in need.

After I was accepted for the job, I was sent to an orientation class in Grand Forks. This was very helpful to me. We heard speakers from various areas of work speak on various social problems. Each one explained the purpose of his work and what we could look for as we go into these homes. There was also a first-aid training course which we all felt was very essential and helpful to us.

When we actually started work, we learned how important the caseworker is to us. The caseworkers meet with us before we go into a home. They tell us about the problems we may expect to find. They set our hours and tell us how they have planned our work. They share their plans for the family with us, so we know the purpose in going into the homes. As we homemakers see problems that arise in the family, we always go to the caseworker and discuss them, and we never try to work them out to solve them ourselves. In most of our cases, the results have turned for the better, but we have learned that we cannot change a family overnight, so there is always more to be accomplished.

We homemakers have learned to be very flexible and to help each other out all we can. In some homes all of us have had a turn. In one case, the first homemaker that went into this home got the children all cleaned up. She taught them to bathe and washed their hair. She helped the mother to see how important this was. They sorted out the clothes, and made sure the children all had clean clothes for school every day. It wasn't long before the teachers noticed a change in the children. They were accepted better in school by the other children. They were cleaner and neater in appearance. The husband of this homemaker became very ill and she had to resign to care for him. The next homemaker assigned to this same home continued where the previous homemaker had left off, and helped the family get a few cooking utensils and also a washing machine. She taught this mother of nine children how to bake bread and rolls, and provide better care to her children. We sent up menus for her and helped her cook a variety of meals instead of just boiled potatoes, fried hamburger, and beans. The mother and father didn't drink, and they seemed very devoted to each other and to their children. But they just didn't know anything about homemaking. They were very willing to learn, and we think we were of great help to them.

We have all had a turn at caring for an elderly man, shopping for him, washing his clothes at the laundromat, preparing some meals, and mainly just visiting a few hours a week with him. He is quite alone and very lonely. We have made it possible for him to remain in his own home. We have all been on this job as it is one where the schedule can be flexible and we can work it out to fit in with other assignments.

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* Speech given at 1967 North Dakota Conference of Social Welfare, Bismarck, North Dakota, September 25, 1967.

My very first case was in a fatherless home. The mother of four children had a serious illness and had to be hospitalized. I worked in the home during the day--doing all the things that were necessary to keep the home clean and the children as happy as possible under the circumstances. During the nights an aunt of the family cared for the children. We believe we were able to save these children from the fear they would have had in going into a foster home. This was a relatively short-time job as the mother was soon well and the family restored to normal. I was happy to be able to keep this family together in their own home.

In another case, which I have found very rewarding, one of the parents has a severe physical illness. She has three young boys at home, who also have the illness, which is painful and disfiguring. This is very upsetting to the parents. They are both very nervous. They yell at the boys a lot, and they are a bundle of nerves too. The nine year old was getting so he didn't want to go to school. He would cry and come running home, so either the mother or father would have to walk to school with him. Their marks were also getting poorer, and the mother didn't have the time or patience to help them because she was sick and so upset all the time. Her biggest household problem was washing clothes. I went into the home two days a week and helped her. This gave her more time to take care of her illness. It also gave her time to relax and have some free time when the boys came home from school. It wasn't too long before the little boy got over some of his fear at school. As the mother relaxed some, the children did too. Their marks improved, and this made the mother much happier. The father was happier too as he didn't have to listen to all that yelling when he came home from work. One day, when I was hanging out a few clothes, the boy was out there with me, and inside the house the mother was singing "Red Roses." I'll never forget how the boy looked at me and said, "Do you hear my mother singing?" I said, "Yes, I do." and he said, "I haven't heard her sing for a long time. She really must be happy." It made me happy too to hear him say that.

We have had several other very interesting cases. One of our homemakers cared for a large family daily for five months while the mother was in the hospital. The father cared for them at night. The children had a chance to stay with their father in their own home. As the mother has regained her health and returned home, we now do not go every day, but only once or twice a week to help her. The entire family is so glad for the help they received.

We have learned that it is necessary for a homemaker to be a very good listener. It seems to help our families if they can tell us what's on their mind while we are helping them with their work. We are part of the welfare office team and we report to the caseworkers any changes in the family living, or anything at all that may be helpful to the caseworker and the family. The caseworker sees the family regularly to help them understand and work on their problems.

We homemakers have always been ready and willing to go into any home where we are needed. And after being there for a while, as we see improvement in the home, it is very rewarding and gives us a great satisfaction that we are doing something for someone.

IV THE PURPOSE AND FUNCTION OF HOMEMAKER – HOME HEALTH AIDE SERVICE*

From STANDARDS FOR HOMEMAKER-HOME HEALTH
AIDE SERVICE *of the National Council*
for Homemaker Services.

Homemaker-Home Health Aide services are multiplying rapidly throughout the country. They are developing under a variety of auspices not anticipated even by the far-seeing individuals who initiated the first such services in the early part of this century. They have earned their popularity as adjuncts to certain of the helping professions -- medicine, social work, public health nursing -- and especially because of the direct and practical help they have given to people. Much of the present demand for the creation and expansion of homemaker programs is due to the growing conviction throughout the United States that, generally, people of various ages and problems are happiest in their own homes if safeguards in necessary services are offered to them.

Homemaker services, in their present form, originated in this country in the early nineteen-twenties under the auspices of voluntary social agencies: concern then centered on children. It was believed that children, who had been deprived of their mother's care through illness, death, desertion or temporarily for less dramatic reasons, could profitably remain in their familiar surroundings if homemaker services were provided to maintain home values for them. The voluntary social agencies have at this time diversified their efforts; they are still, however, the largest providers of homemaker service. Public welfare agencies initiated their first homemaker programs -- now rapidly expanding -- during the mid nineteen-thirties. Public health agencies, both voluntary and official, recognized later the value of homemaker service for various diagnostic groups cared for in the home and many programs are now part of local visiting nurse associations or health departments. A heartening aspect of the current expansion of homemaker service is the concern of Federal and State departments of welfare and health that this service be provided through local programs for many people disadvantaged by poverty and chronic disease. Because they believe the service, where indicated, will assist families to raise levels of living, and bring comfort to individuals with chronic illness, they are willing to furnish funds, within the limits of their legislative and budget authority, to local official and voluntary agencies for on-going and demonstration purposes.

Although homemaker programs originated, as stated, primarily as a service to children -- and still place the well being of children among their most important objectives -- they have gradually extended help to other groups: the aging, blind, mentally retarded and physically handicapped children and adults, convalescents, the chronically ill and the mentally disturbed. It should be emphasized that service is provided to these and other appropriate groups in their own homes by professionally supervised, trained persons -- homemakers. Homemakers are staff members of an organized non-profit community agency: they are selected and assigned, according to the need of the individual or family for help, after the professional staff of the agency has evaluated the applicant's needs and determined whether the homemaker service can meet them.

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* Generic term "Homemaker" used throughout the Code.

Valuable as homemaker service is, it should never be regarded as a panacea. No matter how much warmth and good management homemakers offer, certain homes are not for children. It is equally true that older people, the blind and other similarly disadvantaged groups may be isolated and lonely unless more recreation and emotional support is offered than can be given by a homemaker service at its best. The handicapped and chronically ill in various diagnostic groups may gain more facility in self-management and activities of daily living or obtain other needed care in group setting, where medical supervision and other professional services are readily available to them in adequate amounts. The professional staff of the homemaker agency again must, and does, accept the responsibility for reviewing all facets of the applicant's problem and for determining whether it can best be solved by homemaker service or another plan.

I--What is the essence of homemaker service? Its true purpose has remained constant, although demands for it have resulted in an increasingly wide variation in groups served.

Homemaker service is provided to maintain, strengthen improve and safeguard the home and family life for individuals and family groups when such service is appropriate.

II--The homemaker agency fulfills its purpose through provision of service to meet the diagnosed needs of a variety of individuals and families. The contribution of homemaker service to families will differ, to an extent, from that offered to individuals. It is implicit in a family situation that even a poor home will provide certain emotional supports, through its family relationships, that are not available to the individual living alone. Many families, nevertheless, will need a broad range of services from the homemaker program and from other agencies in order to offset a family breakdown. A homemaker program contributes to families in many ways.

1. It enables children to remain at home, if the environment is favorable, when the usual homemaker, generally the natural mother, is incapacitated by illness or when death, desertion or other reasons deprive them of her help.
2. It is increasingly used to help teach young, inexperienced migrant, or irresponsible mothers improved methods of household management and child care and to lighten the burden of those mothers unable to cope with home management needs of a large family.
3. It provides, in conjunction with protective social agencies and the courts, protective care to children in their homes during a diagnostic period and until an optimum on-going plan is developed.
4. It frees an employed adult, responsible for the economic support of the family, from the direct care of children, older or chronically ill members of the family so that he can maintain his job responsibilities during periods of home crises.
5. It provides, through assignment of a homemaker, a professionally supervised, trained person to give attention to an individual family member requiring simple personal care and thus enables other family members to fulfill their usual responsibilities in the household and toward each other.
6. It enables family members, who must provide continuing personal care to an elderly, blind or chronically ill family member, to have temporary periods of rest or relief on a planned basis, either through daily assignment of a homemaker or through a block assignment for away-from-home purposes, including vacations.

III--Reason for the placement of a homemaker will differ somewhat if the applicant is an individual living alone rather than a member of a family; basics in home-management will be the same. Homemaker service can benefit individuals in various ways.

1. It allows individuals to remain in familiar home surroundings and so helps them avoid unnecessary placement in a hospital or other institution or foster home.
2. It provides care for individuals in order to lessen the stress on the usual caretaker, if there is one, and to free time for other urgent family responsibilities.
3. It supplements the professional service of social agencies necessary in protective care programs for appropriate older or mentally incapacitated individuals.
4. It supplements, and is supplemented by, professional health services through provision of necessary personal care of individuals during their physical and mental rehabilitative processes; it helps promote facility in self-management and activities of daily living; it is supportive to the over-all medical treatment plan.
5. It establishes a favorable home climate for convalescents and thus helps them to return home from hospitals or other institutions without unnecessary delay.
6. It lessens, through the personal care, home management and emotional support provided by homemakers, the economic physical and emotional burdens of chronic illness for various diagnostic groups.

Summary Statement on Purpose and Function

Homemaker service exists to maintain, strengthen and safeguard family life. It is provided by a tax supported public or voluntary non-profit community agency, the homemakers performing under agency aegis are qualified and trained, and are selected, assigned and supervised by the professional staff of the agency. Children and adults with various medical and social diagnoses benefit through homemaker service.

Originally organized to serve children, it has broadened its scope to include many economically, physically and emotionally disadvantaged groups of both children and adults. The help given to an individual living alone or to a family group may differ according to the need of the individual or the family group. The professional staff of the agency, therefore, continually evaluates the service plan and determines its on-going suitability.

V RECRUITMENT AND TRAINING OF HOMEMAKER-HOME HEALTH AIDES*

BRAHNA TRAGER,
Executive Director
San Francisco Homemaker Service

We have been hearing a good deal lately about homemaker service and its off-shoot, home health aide service. Here in the United States it is the johnny-come-lately of the range of in-home services in the medical care field, and what we do hear depends a good deal on where we happen to be. From the family agency we hear that the homemaker is a kind of fairy godmother who, with miraculous skill, fortitude and understanding manages to keep the family intact no matter what the circumstances may be - poverty, disease, abandonment, alcoholism - and, to reduce things to reality a bit, - during maternity hospitalization and other long or short term family crises "in the absence of the normal homemaker."

From the generalized Homemaker program (such as the one I represent) which is oriented to chronic illness, disability and aging, we hear that the homemaker or home health aide prevents or eliminates the need for institutional care; that she can replace relatives, nurses, housekeepers and social workers - and again, more realistically that she can be a sustainer of the plan for the patient at home - provided it is a good one - for short or long periods of time.

From private physicians, some hospitals and even some home care programs we hear that the supervised homemaker or home health aide is a fancy, over-priced, over-trained, over-supervised character who is unnecessary since "anybody can do simple housework, give a bath or even do a few nursing procedures" - and what is needed is just the nearest employment office.

And more recently we have been hearing about the homemaker as a teacher in the home who rehabilitates the normal homemaker. We are also hearing about homemaker and home health aide service as a fruitful solution in the poverty program; it is to be used to take women off the relief rolls by training them in large numbers to become professional homemakers. Here it appears that the program will be geared to the needs of the employee rather than to those of the consumer of service.

There is an equal amount of confusion when we try to make our way through the variously titled groups of helpers in the home these days. As a worker in the field I am hard put at times to explain to the uninitiated the precise difference between a homemaker and a housekeeper; between a homemaker and a home health aide; between a home health aide and an attendant; between an attendant and a practical nurse and so on, through a whole range of sub-professional groups of workers who are being used in one way or another in connection with the care of the sick at home.

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* Paper given at the Workshop on Administering and Financing Home Care Programs, University of Michigan, School of Public Health, Ann Arbor, Michigan, March 22-26, 1965.

This multiplication troubles me for several reasons. The least important, from my point of view, is that we are going to be wasting a good deal of time defining function; establishing criteria for selection; setting up specialized training programs which differ from one another slightly but in which those slight differences are going to become important to the people who set them up. The most crucial reason from my point of view is that we are in danger of seeing further fragmentation in what is already a somewhat chopped up picture when we look at services for the chronically ill.

Since I have come all the way from California sunshine to this beautiful but chilly place to talk about recruitment and training of a particular kind of in-home personnel, I make this beginning because it does become important to decide what kind of service we want if we are to make some general statements about the preparation of the people who are to provide that service. And general statements are difficult if, of the twenty-five or more participants in this workshop, you are each thinking through the range of, "just the housework", to "Why not give insulin? We teach family members to do it." I am going to try to generalize in an area between those two extremes in order to develop, if possible an understanding of what a group of well selected, well trained and properly supervised women (and men too, occasionally) can do to sustain a plan for the care of the sick at home.

It seems to me that there are two common denominators that we can establish as a guide to the recruitment and training of these people. The first is that the service is provided at home. The second is that it is provided where illness usually chronic, is the focus of our concern.

Now it may seem to be a fairly simple business to send someone into the home to keep things going. It usually is, in a normal situation. In a normal situation, of course, one could simply call the nearest employment agency and hire a day worker. But in-home services are not provided in the normal situation. Illness brings with it, as we know, a whole range of associated problems: emotional, financial and environmental; and for the individual who is ill, and for his family, the stranger who comes into his home, to be associated with him in the most intimate way and on a continuing basis, can either be a great source of strength or an enormous irritation. The doctor comes and goes; so does the nurse; so does the social worker. If they seem cold or kind there is an interval between visits and new approaches to the relationship can be made. But the homemaker or aide who sings at her work all day, day in and day out when song is not appreciated; or who never talks -- or talks too much -- or is "bossy" or who cooks the same thing every day -- or who doesn't cook the same every day -- can be an inescapable source of misery -- acute because her services are needed whether she is irritating or not.

In brochures that are coming from most homemaker programs today we hear these women described as "mature, flexible, adaptable." Now how does one go about recruiting a "mature, flexible, adaptable" woman so that her services will be appreciated in the home of a cardiac who is compulsive about cleanliness and who can never be satisfied that someone else can do things properly and so that they will be equally appreciated in the home of a social arthritic who wants conversation as a substitute for lost mobility?

The answer to that question, of course, is that it is not possible to find such women. We can and do find women with certain personality traits. The rest must be provided by the agency as a part of a program of continuous training.

What we look for in our first interviews is primarily an attitude. We are wary of the person who "just loves to help people!" because that eagerness often becomes an unhealthy involvement. We are wary of the women who "always wanted to be a nurse," for even more obvious reasons (although we have occasionally been able to channel that interest constructively). It is the woman, young or old, educated or uneducated, who has a kind of smiling calmness, who seems to take pleasure in putting good food on the table; who seems to enjoy the idea of making a clean serene environment, who does not appear to be defensive, who can, as social workers say, "relate" to people - she is the one we try to find for this service. Once found we are committed to a rather large investment in the way of training.

First of all, we make every effort to build in her a strong sense of indentification with the agency and its purposes. Regularly three or four times a year our women are brought into the office in small groups and together we review the policies of the agency and the reasons for these policies. They learn that they must be punctual, not because they are wasting time and money, but because sick people often cannot bear to wait and become apprehensive after even a few minutes of waiting. They learn that they must never argue, no matter how unbearable the situation becomes because aregument may mean one thing to them and another to the patient - but they are told that they can call the office and complain long and loudly about an unfair situation and that we will listen with sympathy and patience. They are encouraged to call or to come into the office whenever they have the slightest doubt, the slightest question about any family, any situation. If they are asked to do something that is not in the rules they are taught to say "I will call my office," and they know that one of us will take the responsibility for difficult explanations. They are never sent into a home without a description of what they will find and an explanation of what they are to do.

We ask our women to be good observers, to try to notice whether people want to be talked to or whether they would rather be left quiet and we often help them to decide this. We discuss with them ways in which they may approach families in different circumstances and we keep them firmly out of concerns with the financing of care or people's financial circumstances. We do ask them to be careful if they notice that people must manage their money carefully. We ask them to notice changes in emotional tone, in physical well-being or deterioration, and to let us know if for some reason they sense that things are not going well. We do not use them in any kind of authoritative way. They are not required to prevent an alcoholic from drinking or a patient with chest disease from smoking. Where the drinking and the smoking are going on, the homemaker does keep us informed, but in our work with the family, every effort is made to keep the homemaker free of the kind of entanglement which would make her a spy in someone's home. Her attitude is always that she works in the home of the family to serve that family and that we are there in order to help her do it as well as possible.

In the course of her work she will, we hope, develop a strong relationship to her supervisor - one in which she feels quite free to suggest as well as report - and one in which she will always be able to be frank about her misgivings as well as her achievements.

We have found that this kind of training is probably the most productive, but we do provide formal training as well.

I spoke before of the dangers of overspecialization in this field and I have often thought that the people who dream up various categories of services to be provided by different and specially trained people are perhaps removed from the realities - considerably removed. We have found that the person who needs to be cared for at home rarely needs care that is static. In the beginning we tried to stay out of personal care and to confine our women to such tasks as household maintenance, shopping, cooking, the preparation of special diets and the provision comfort and security in personal interaction. We thought that if personal care of any kind was needed it should be provided in some other way. I think we made a distinction, or tried to between managing the environment and touching the patient - and we thought that touching the patient was a "nursing function." We found, however, that the patient who was able to get up and dress one day, needed help in dressing and going from bed to chair the next. We had innumerable telephone calls from our women about the patient who had bathed herself for weeks, but who was now sitting in the bathtub and couldn't get out without help, or the patient who had not needed help in walking before but now must remain in her chair unless she could be helped. We found that in chronic illness change is the order of the day, and that it was not practical - not even possible - to have a helping person in the home who could not help in situations such as these. Our decision to use our women flexibly, to eliminate shifts in staff or the addition of specialized personnel for such tasks meant that we must train our women to perform safely in situations where personal care was required, either occasionally or regularly.

Simultaneously, Federal regulations in the public assistance program described a kind of in-home personnel which was called the "home health aide" and authorized the purchase of such services for recipients of assistance.

In our state the decision was made that standardized training should be provided for such personnel and a committee composed of representatives from various programs providing home care, homemaker service, rehabilitation services as well as from the various professions involved in medical care developed a program consisting of 120 hours of training. Upon satisfactory completion of this training a certificate entitled the trainee to function as a home health aide; the committee recommended that this should be under professional supervision and further, that such aides should be reimbursed from public funds only if they were employed in a recognized agency.

This course is given several times each year by our adult education program in a large chronic disease hospital and we have been sending our women to school after they have been with us for a while and we are satisfied that they will work out well.

Briefly, the curriculum is as follows:

Approximately 50% of the time is spent in the development of skills relating to personal services. A good deal of emphasis is placed upon hygienic care such as grooming of hair, skin, nails; shaving, dressing and care of the mouth and teeth; and upon moving activities such as helping the patient in and out of bed, chair, toilet or commode, tub and shower, and carrying out the medical plan through exercise, positioning, foot board, assisting in walking with and without devices and the promotion of self-care activities.

About 25% of the time is spent in teaching basic principles of nutrition, cultural and economic backgrounds, meal planning and serving, food purchasing, food preparation, sanitation and storage, and the preparation of special diets.

About 10% of the time is spent on cleaning and care tasks in the home with emphasis on home safety measures, sanitation and the economical management of the environment.

15% of the time is spent in developing some understanding of the community agency relationships and basic concepts of human development and behavior. In this section emphasis is also placed on relationships to professional personnel such as physician, nurse, social worker and some very brief time is spent in discussion of common medical problems and the implications of long term illness, ethics and confidentiality.

We have found that this training has been the most helpful in those aspects related to personal care. It has not taken the place of regular training sessions which we still provide and which relate mainly to people as individuals. We find that classroom and demonstration training is successful when it comes to helping people in and out of the tub. The on-going program which makes for a real helping personality in the home is the one which develops understanding of why people behave as they do; how people can be helped; why they sometimes can't; what people do with their anger, their sorrow; what despair can do; what hope can do.

Out of this we have added to the constellation of in-home services a source of strength - a person who has warmth as well as detachment; humor as well as sympathy, observant eyes and ears; and, with all this, good nutrition, a clean house and a bath.

It may seem that the millenium has come for the patient at home, and at the risk of destroying that pleasant thought I would like to stress some rather important considerations:

> It is not safe to keep a person at home who belongs in an institution.
>
> It is not even cheaper to do this and I hope we will all stop saying that it is.
>
> It is not possible to build constructive in-home services around an impossible home situation; I mean impossible because of poverty with its associated bad housing, inadequate nutrition and general deprivation.
>
> It is not possible to provide homemaker or home health aide services constructively without the whole range of medical and social services necessary to good home care.
>
> It is not possible to provide homemaker/aide services at all without adequate financing.

VI THE CASEWORKER -- HOMEMAKER TEAM*

JOHNNIE U. WILLIAMS
Specialist, Homemaker Services Division
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Department of Health, Education and Welfare

You and I know that grim poverty, while seemingly a recent discovery, is not new. We have come face to face with poverty for a long time as we "covered our caseloads" in the big cities, the small towns, and rural areas. We see poverty more sharply when inadequate grants fail to meet a family's needs.

We have welcomed the evolution of the Social Security Act and amendments which provide us new opportunities and new tools with which to help families toward self-dependency and self-care. Homemaker service is one such tool. Yet, while homemaker service is widely accepted in theory it remains to be widely implemented in practice. The main stumbling block in the way of developing this service has been money.

Congress has now brought homemaker service within the reach of every forward-looking public welfare agency in the nation. Under the 1962 Public Welfare Amendments, state public welfare agencies may receive 75 percent Federal matching funds for the administration of homemaker service within their programs.

Many states have taken advantage of increased Federal funds and we see accelerated growth of homemaker service in public welfare. Much remains to be done, however, if these services are to be developed in the quantity needed. In a recent speech, Dr. Ellen Winston, U.S. Commissioner of Welfare, emphasized the need to increase homemaker service programs. She said "200,000 homemakers are needed in this country."

In public welfare we estimate that there are now 1,100 homemakers in 168 programs. When you consider that nationally our public assistance programs serve 7.8 million persons, this is a mere beginning if caseworkers are to make substantial use of this resource for overcoming dependency and for raising levels of living.

WHAT IS A HOMEMAKER?

A homemaker, by definition adopted at the 1959 National Conference on Homemaker Services, is "a mature, specially trained woman with skills in homemaking who is employed by a public or voluntary health or welfare agency to help maintain and preserve family life that is threatened with disruption by illness, death, ignorance, social maladjustment, or other problems. A pleasant personality, physical and mental well-being, experience, and training enable her to assume full or partial responsibility for child or adult care, for household management, and for maintaining a wholesome atmosphere in the home. She does these things under the general supervision of a social worker, nurse, or other appropriate professional person connected with the sponsoring agency. She exercises initiative and judgment in her performance of her duties, recognizes the limits of her responsibility, works cooperatively with family members, and shares her observations and problems with those responsible for the homemaker service program." [1]

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* Paper given at the 1965 APWA Southwest Regional Conference in New Orleans, Louisiana, March 21-24, 1965. This paper was published in Public Welfare, Vol. 23, No. 4 (October 1965). Permission to reproduce this paper was granted by the American Public Welfare Association.

Homemaker service can be described in a way that has special meaning for us in public welfare.

> It means a family learning to sit down together for a meal and enjoy one another.
> It means a mother learning to prepare hot, nourishing, tempting meals from surplus commodities.
> It means a curtain to separate and to give needed privacy to a teenager's nook in a crowded bedroom.
> It means an aged widow spending her last years in her own home among precious momentos of her life.

Think what it could mean in the lives of our clients if these services were available whenever needed!

ELEMENTS OF HOMEMAKER SERVICE

But let me stress here that nothing magical happens simply by bringing together a family and a homemaker. Homemaker service encompasses at least four important elements.

The first is administrative commitment. This means that the administrator must have deep interest in homemaker service and conviction about the useful purposes it serves. He must take steps to promote community involvement and acceptance of the service. He must plan for continuing financial support of the service. He must secure adequate staff to operate the homemaker service program and to assure that it is coordinated with all agency services. These steps are obviously essential to sound development of the service.

Next comes administrative activities such as recruitment, selection, training, assignment, and supervision of homemakers. All of these factors go into the development of a homemaker who, we have a right to expect, will be well related to the needs of the agency's clients and able to use her skill in child care, household and money management, hygiene and health practices, in human and practical ways to meet the unique needs of the families with whom she works.

The third element is the social work staff, including caseworkers, who must understand homemaker service, how it may be used in helpful ways and their part in making it effective. Without such understanding homemaker service may just as well not exist. Such understanding implies individualizing the family and planning with them and with the homemaker to meet the family's needs. It means finding out that the Jones children don't like to go to school because the other kids laugh at the way they are dressed. It means finding out that Mrs. Jones doesn't know how to buy the best kind and quality of clothing her AFDC grant allows, and that the children's clothes look half clean and dingy because Mrs. Jones washes everthing once -- in the same tub of water! Mrs. Jones needs someone on the scene to teach her about buying and care of clothing. That "Someone" is a homemaker.

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[1] Doscher, Virginia R., Report of the 1964 National Conference on Homemaker Services, National Council for Homemaker Services, 1790 Broadway, New York, New York 10019, p. 12.

In the assignment of a homemaker to a family and from thereon, the caseworker helps each to understand the other and to work toward a common goal. The caseworker has continuing responsibility to see that the family has what is needed to facilitate the homemaker's work. It does no good to assign a homemaker to help a mother improve homemaking if there are no cooking utensils, bedding, or other household equipment or if the mother is not ready to use the service.

The fourth and last essential concerns the collaborative, working relationship between the homemaker supervisor and the casework supervisor, who must help the caseworker-homemaker team to carry out their respective roles. In order to do this, each supervisor must share knowledge with the other. They must work out arrangements for case conferences, be alert to problems which inevitably arise, and they must be able and willing to take the necessary remedial action. Each needs to be active in promoting staff and community acceptance and appropriate use of homemaker service. Each should provide the agency administrator with information needed to evaluate and to improve the over-all quality of the service.

These four essentials that go into homemaker service make one thing clear: it would be a mistake to think of homemaker service as an isolated entity without relation to the vital functions which we carry every day. Homemaker service in public welfare, is indeed closely coordinated with other basic social services. It involves a casework plan based on a social study of the needs of an individual or family and careful selection from among agency and community resources -- day care, foster homes, nursing homes, and other institutions -- the service most appropriate to the family's current need.

HOMEMAKER SERVICE, A DIAGNOSTIC TOOL

Now let us look at some of the situations which require homemaker service to complement casework planning.

> Mrs. Martin, an AFDC mother of three children ranging in age from two to five and a half had been hard hit by the sudden accidental death of her husband the previous year. She has been highly dependent on him for managing their business affairs and for help in caring for the children. Normally a somewhat shy, withdrawn person, she has made almost no friends in the new community to which the family moved when Mr. Martin found a job after several months of unemployment.
>
> The caseworker noticed that over a period of months following her husband's death, Mrs. Martin gradually became more and more quiet. Often when she visited the home the shades were drawn and the interior of the home unlighted. Mrs. Martin was frequently in bed complaining of a variety of physical symptoms which were ruled out by subsequent physical examinations. The children, half dressed or still in night clothes played outside or inside the house with no supervision from Mrs. Martin.
>
> The caseworker was concerned. Was Mrs. Martin physically ill? Was she suffering from a depression? Was she dangerous to herself and/or the children? How could the children be cared for while Mrs. Martin received the attention she needed?

> The first step, of course, was to have Mrs. Martin's condition evaluated medically. This meant, at least in the beginning, that Mrs. Martin would have to be away from home on many occasions for several hours at a time. Should a neighbor be requested to baby-sit? Should the children be taken along to the doctor's office? In thinking through what was needed by this family at this particular point in time, the caseworker decided that homemaker service was the best answer. While neighbors frequently respond to and may be used in temporary emergencies, this family required more than could be expected from a neighbor.

A person was needed here who had sympathetic understanding of what the caseworker strongly felt was mental illness. This person would need to care for the children -- to bathe, clothe, feed, supervise them and to fill their emotional needs which Mrs. Martin seemed unable to do at this time. The home would have to be attended. Equally important, this person would need to be able to work on a day to day basis with Mrs. Martin along the lines suggested by the doctor via the caseworker. She would have to share pertinent observations of Mrs. Martin's behavior and attitudes so that a better evaluation could be made of her condition and final plans worked out accordingly. Such a person is a homemaker, trained to work in situations such as this one, clear in understanding her role of supporting the mother and able to relate to her colleague on the agency team -- the caseworker.

Here we see the role of homemaker service in diagnosis, in helping the caseworker to determine more precisely what the problem is and what needs to be done about it. In this case, the children's care and protection is assured by the assignment of a homemaker while the necessary evaluation is made. In addition to caring for the home, the homemaker will, by sharing observations, enable the caseworker and the doctor to determine whether Mrs. Martin is, in fact, mentally ill and what plan for treatment is best in view of her total circumstances.

HOMEMAKER SERVICE, A PREVENTIVE MEASURE

Another case illustrates homemaker service as a preventive:

> Feeble and nearly blind, 82-year-old twins, and their "young" 70-year-old brother, all OAA recipients, managed quite well in their rural farm home until the latter died of a heart attack. He had done the errands and most of the heavy work around the home. Now these two old people could no longer maintain themselves independently and faced the possibility of nursing home placement. The caseworker recognized and appreciated their desire to remain in the home which they had inherited from their parents. Having cleared with the doctor that their physical condition was no barrier to their remaining at home, the caseworker suggested homemaker service. The twins were delighted with the homemaker who spent a few hours each day with them. She prepared meals, did light housekeeping and laundry, and brought them news of community activities. Occasionally, she took them with her when she went shopping, but always she sought their suggestions about needed supplies. While caring for them, the homemaker was sharing observations for their mental and physical health with the caseworker.

Again, the information given to the caseworker helped her to know how long these aged persons could remain in their home. As caseworkers, you should know that homemaker service is not the best answer in all situations, for all time. There may come a time when aged persons such as these require nursing home care, hospital care, or other group living arrangements such as foster family care.

RAISING LEVELS OF LIVING

Using homemakers to help families raise their level of living is one of the most exciting departures from traditional practice.

Let us clarify what we mean by "raising the level of living." It does not mean that we expect to provide public assistance families with luxuries, or with the same food, clothing, or housing which middle income families have. It does mean that we seek to help them have nutritious food in sufficient quantity; clothing which is suitable for their needs; and housing which is clean, safe, and conducive to the kind of family life which stimulates healthy physical and mental growth of children.

All of us have struggled with the problem of helping families who bear the brunt of community criticism. These are the families whose children seem unable to learn; who go to school dirty and without lunch. These are the families who make meals of cold cuts and crackers, of soda and cookies. These are the families who make very poor use of their limited assistance grants, and who can never plan for a month ahead.

As caseworkers we understand that this is not a simple, uncomplicated problem. We know that many such families live the way they do because they have no opportunity to live differently. We know that parents repeat with children their own life experience. This was the situation with Mrs. Harvey when she poignantly said, "Everybody tells me I don't take good care of my children, but nobody shows me how."

> Mrs. Harvey's situation was referred to the agency by the police who alleged that she was a neglectful mother and recommended that her children "be taken away from her and placed in foster homes at once!" The police had been called to her home the previous night, upon complaint of neighbors, that Mrs. Harvey's six children, ranging in ages from one to six years, were alone in the apartment and were not being cared for. The landlord claimed that this was a frequent occurrence. The police described Mrs. Harvey's children as dirty and unkempt. The two-year-old twins were unclothed except for undershirts. They had remnants of feces on their bodies, and were sleeping in a bed with a worn-out dirty mattress. The baby was nursing a bottle of curdled milk. All of the children seemed to be underweight and malnourished. Mrs. Harvey was hostile toward her landlord for reporting the situation to the police whom she felt had made an unfair evaluation of the previous night's incident. She was resigned to the possibility of having her children removed, but defended her care as being the best possible under the circumstances. Given these circumstances, one would reasonably question Mrs. Harvey's capacity to use help. But she said, "Everybody tells me I don't take good care of my children, but nobody shows me how."
>
> The caseworker's social study disclosed that Mrs. Harvey was a 23-year-old woman, who came from a deprived background. Her first

> child was born as the result of a criminal attack at the age of 13. (This was verified by court records.)
>
> Subsequently, she was married and her second child was born. After a brief period the marriage ended in divorce. Mrs. Harvey then began a relationship with Mr. Simmons, a married man many years older than herself. Four children resulted from this relationship.
>
> Mrs. Harvey was completely dependent financially upon Mr. Simmons, who provided support within his means. A year before the neglect complaint was made to the welfare department, a fire left her almost entirely without household furnishings or clothing. Though pregnant, she had rescued her children from their basement apartment.

The caseworker suggested the assignment of a motherly homemaker who, on a day-to-day basis, could teach Mrs. Harvey how to give better care to the children and the home. Together they were soon bathing and dressing the children, cleaning and organizing the home, and making the best use of the limited clothing and household furnishings and supplies Mrs. Harvey had. At the same time the caseworker saw to it that immediate needs of food, clothing and household supplies were met. In addition, the caseworker established Mrs. Harvey's eligibility for an AFDC grant which supplemented the support from the former husband and Mr. Simmons. She helped Mrs. Harvey and Mr. Simmons to establish paternity of his children and, thus, clarified their legal status.

Over a period of months, the caseworker-homemaker team worked with Mrs. Harvey. Let us see what they accomplished: (1) The homemaker, through her close contacts in the home, learned exactly what basic essentials in clothing, bedding, dishes, cleaning equipment and cooking utensils were needed by this family and the caseworker tapped community resources to meet these needs which required large immediate outlays of money. (2) Mrs. Harvey learned by the homemaker's example, to give better care to the children, giving attention to their diet, hygiene, rest, and supervised play. The caseworker helped Mrs. Harvey to secure medical care, as needed. Mrs. Harvey also learned to intervene in the children's quarrels calmly, and was able to give up her past screaming, ineffective efforts at discipline. (3) The homemaker helped Mrs. Harvey to learn better to shop and to plan expenditures now that she had a predictable, though still limited, income. They watched the newspapers for bargains, budgeted, and went shopping together. (4) When Mrs. Harvey began sharing with the homemaker her changed feelings toward Mr. Simmons, the homemaker listened sympathetically, but encouraged Mrs. Harvey to seek counsel from the caseworker. As some of her most pressing, immediate problems were relieved, Mrs. Harvey began to think of the future in terms of greater satisfactions and acceptance for herself and her children.

In the case of Mrs. Harvey we can see an important by-product of homemaker service -- the change in attitude, the change in perception of self, the look toward the future with greater optimism which results from increased feelings of self-reliance in dealing with one's life situation. Mrs. Harvey said, "I didn't know I could feel so good and still be poor."

Over and over, in literally thousands of cases of this kind, the homemaker, working in practical ways within the home itself, serves as an agent of change, a "culture-bearer." She is close to the family in unguarded moments. She knows them in intimate ways that the caseworker could hardly be expected to know no matter how frequently she visits. And the homemaker carries out her role not by exhortation, but by demonstration; not by preachments, but by example. At the same time she is, as one mother put it, "an uncritical friend." In the ways cited, the homemaker contributes to the caseworker's plan for helping familes raise their level of living.

WAYS A HOMEMAKER CAN HELP

Out of your experience you can no doubt think of a variety of situations in which homemaker service can support casework planning. I might suggest a few such illustrations:

> 1) where an adult in a hospital or nursing home can return home if there were a homemaker to perform the necessary household duties or to help with routines of daily living;
> 2) where a family requires interim help until placement outside the home of a child or adult can be made;
> 3) where a mother is absent from home and a substitute is needed to care for the children;
> 4) where a mother is home but unable to care for children due to illness, mental retardation, or similar incapacity;
> 5) where a mother is so involved in the care of a retarded, ill, or handicapped child that other family members are neglected.

In other words, impaired functioning, for a variety of reasons, which interferes with or threatens to interrupt family life is usually the caseworker's first clue to the need for homemaker service.

All of us have a role to play in stimulating the development of such services where they do not now exist. I remind you, again, that we now have the enabling legislation, the money, and technical assistance needed to get these services underway. The necessary ingredient now is the motivation and the will of boards, administrators, staff and tax-levying bodies.

I am reminded of what Charlotte Towle, a pioneer in public welfare, told us about making our agency programs suited to human needs. To do this, she explained, "They (agencies) must continuously have the breath of human life breathed into them."[2] Homemaker service can add a breath of life to our public welfare programs.

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[2] Towle, Charlotte, Common Human Needs, U. S. Government Printing Office, Washington, D. C. 20402, 1945, Introduction, p. vii.

VII HOME HEALTH AIDE SERVICES ARE HERE TO STAY*

MADELYN N. HALL
Deputy Director
Community Nursing Services of Philadelphia

Public health nurses have long pondered the problems of caring for the sick and disabled in their own homes. They have seen families disintegrate under the burden of one family member's illness. They have helped with plans to place lone, sick individuals in nursing homes or other institutions, only because there was no alternative. They have watched chronically ill patients deteriorate knowing that many could have reached a desirable level of rehabilitation if they had had more intensive care service and more frequent visits. But with a multitude of services to provide to many people, this has not been feasible. Nor has it been desirable to relegate the skills of a highly qualified public health nurse to activities which could be provided by a competent family member or substitute family member.

At Community Nursing Services of Philadelphia, groups of central office administrative staff and supervisory personnel met to discuss the possibility of employing substitute family members -- home health aides -- to provide certain needed services under the direction and supervision of a public health nurse.

We wanted an opportunity to test our belief that the nonprofessional human resources of any given community have not been utilized to their maximum potential. And we intended to tap one such resource -- mature, middle-aged women who knew how to manage a disturbed home, had faced illness either at home or at some job, had had experience with elderly persons, liked people, and were capable of following directions.

At our meetings we discussed what kind of operational organization we would need, which skills a nonprofessional person would need to safely provide care in the home, what traits we would want her to have, and where and how we could recruit these women. We believed that nonprofessional persons could carry out these responsibilities:

1. General personal care -- bathing, feeding, dressing, assistance with walking, and the use of simple self-help appliances.
2. Paramedical care -- supervision of patient in taking oral medication; taking and recording temperature; recording intake and output.
3. Housekeeping -- light cleaning, washing, ironing, simple sewing.
4. Food service -- purchasing food and household supplies; planning, preparing and serving meals.

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* This paper was published in Nursing Outlook, Vol. 14, No. 6 (June 1966), pp. 44-47. Permission to reproduce this paper was given by Editor, Nursing Outlook.

Job specifications, application for employment, and personnel policies for home health aides were prepared with the needs of the ill at home in mind. It was agreed that the aides would normally work a 5-day, 40-hour week, be available any day from Monday through Sunday, and be willing to accept evening and night assignments as needed. Because work beyond 40 hours was anticipated, provisions were made for reimbursement at the rate of one and one-half times the regular salary. Fringe benefits and policies, such as vacation, holidays, and sick leave were the same as for other agency employees.

All of this was going to take more money to implement than our budget provided. Our ideas and plans were of sufficient value, however, for the Division of Chronic Disease, Public Health Service, to give us a 2-year contract for the financial support needed to develop the project.

Our recruiting efforts began with sources suggested by the administrative staff: Jewish Family Service, Family Service of Philadelphia, Episcopal Employment Service, Home Maker Service of the Board of Education, Health Education Office of the Philadelphia Department of Health, newspaper releases, and our own nursing staff. This multipronged recruitment effort resulted in 87 inquiries about the position. Of the 59 who made application, 31 were acceptable, giving us clear indication that our recruitment sources were good ones.

The total project is beyond the scope of this article but I shall highlight our experimental steps, trials, errors, and successes so that others may benefit from our experiences.

We employed 18 of the 31 applicants. They have been a stable group, considering only two have resigned. One was pregnant and the other one did not like the work.

A decision which proved most popular with the home health aides was the wearing of a uniform, with a choice of colors. Perhaps significantly, all the home health aides have selected blue, the color usually associated with public health nursing. The addition of the agency pin gives them a sense of really belonging to the Community Nursing Services.

Acceptability for employment was determined by a process comprising five steps: (1) application, (2) interview; (3) comprehension tests; (4) references; and (5) physical examination, including chest x-ray, tuberculin test, Wassermann test, Papanicolaou smear, and referral to medical care for treatment of abnormal findings.

GETTING STARTED

Community education and publicity were essential both as supportive measures for the project in progress and with a view toward continuing the home health aide service if the project met its objective.

A brochure introducing the service was the first major publicity effort. It was developed with the assistance of a professional artist and a script writer who were employed for this purpose. It was mailed to all private physicians located in the project area, and distributed to Community Nursing Services board and committee members and other influential citizens. In giving speeches in and outside the city, the professional staff often found the opportunity to talk about home health aide service, and always found intense audience interest.

Training responsibility for the home health aides was shared by service staff and the educational staff. We have found that careful orientation is crucial, but it need not be an overly elaborate plan. It can be done in a week's time, and still include a realistic interpretation of what the job responsibilities will be, specific skill training, and attention to the self-development need of every individual.

We worked closely with the district supervising nurses in establishing the relationship between the public health nurse and the home health aide. Through the process of many group discussions, we decided that the public health nurses would:

1. Select patient's fitting criteria for home health aide service.
2. Observe the patient's physical care needs, by making closely spaced visits while establishing relationships with family.
3. Set realistic long- and short-term goals as part of the total care plan for the patient.
4. Learn from the family what the patient's and their needs and desires are, and plan with them and with the physician.
5. Explain home health aide services and limitations to family and physician.
6. Work out payment for service with family using usual fee scale. Collect fees or arrange for billing.
7. Share with the supervisor her assessment of patient care needs, her plan for the patient's care, and her evaluation of the home conditions on which she bases her request for home health aide service. (She should have an alternate plan if a home health aide is not available.)

When an aide has been assigned to a home, the public health nurse should:

1. Give the family one memorandum on home health aide services when she makes the visit to work out the aide's duties.
2. Write specific detailed plan for the aide to follow, using the home health aide activity schedule. The plan must be geared to the total plan of care and should be included in the patient progress notes.
3. Introduce aide to family.
4. Demonstrate and observe all activities new to the aide. (Duties must be confined to those included in the aide activity schedule. Other activities must be approved by administration.)
5. Oversee the aide's performance in carrying out duties as outlined.
6. Decide when the aide is no longer needed, in consultation with the public health nursing supervisor and with the family, physician, social worker, or anyone else who has been involved in the patient's care.
7. Communicate the date for terminating aide services to the home health aide and family.
8. Assist in evaluating the aide's performance by writing a report at termination of every assignment.

CONTROL MEASURES

The scope of service given by aides is difficult to control. They may go beyond their stated responsibilities, not so much because of their own inclinations, but on the nurse's instigation or to please family members. Because public health nurses teach family members selected intricate technical procedures, they may feel that the home health aide should be taught to carry out these procedures. Family members occasionally expect the aide to do things which are not in line with her assigned duties. These attempts to broaden the aide's responsibilities may defeat the purpose of the assignment.

Another complication is that a single aide must relate to many different persons in a relatively short period of time. Aides are assigned citywide. They may work in any one of ten health districts, though we try to curb this possibility. Even when an aide stays within the confines of a single district she may work with one district supervisor, four assistant supervisors, and 30 staff members -- each with her own peculiarities. Multiply this possibility by ten and supervision becomes confusion.

To give the aide one single person to whom she can relate, we have set up the position of nurse administrative assistant, responsible to administration for coordinating the home health aide program. She follows through on the orientation of all new aides to insure that all scheduled demonstrations and return demonstrations in the field are completed satisfactorily. She shares in the supervision of the aide's performance during the 6-month probation period, making home visits in every new patient's home to observe whether the aide is following the public health nurse's activity plan in carrying out acceptable procedures. She gets to know the aides, thus she can be most helpful in assigning the right aide to the right home on the basis of family and patient needs. Her other duties are to provide an equitable distribution of aides in terms of service demands and to keep statistical data on cases seen and hours worked. It is possible that when the home health aide program has been firmly established the nurse administrative assistant will no longer be needed; however, she is now providing a valuable service.

PRIORITIES FOR PLACEMENT

Priorities for placement of the aides were set in terms of the duration of the experimental project, the current policies of the agency, and hopes and plans for the future. The conditions we imposed are reported here in no rank order. Their relatedness is self-evident.

The patient had to be at least twenty-one years of age, residing within the boundaries of north central Philadelphia (the above limits have since been eliminated), suffering from a chronic or extended illness expected to last beyond 30 days, and living alone or with family members who could not assume responsibility for care or needed temporary relief from such responsibility. The care of the patient had to be of such a nature that it would require the skills of a professional nurse who would make use of the home health aide as an assistant trained to function in the specific situation.

The service was intended to help a patient recover the ability to care for himself. It was not to be extended beyond 90 days. The patient had to be under the care of a physician associated with a hospital outpatient department or in private practice. The home health aide was placed in a home only when agreed to by the family and the physician.

Service was given regardless of the family's ability to pay. In general, aides spent either four or eight hours a day in the home. In exceptional situations, services were provided seven days a week, or were extended beyond 90 days. In some situations, they were given on a shift basis;

for example, from 10:00 A.M. to 7:00 P.M. (with an hour break for a meal and relaxation) to accommodate the working hours of the wage earner in the family.

The home health aide was to remain in the home until the crisis was resolved in one of four ways: the patient was rehabilitated to an adequate level of selfhelp; a family member was able to assume or resume care; the patient was admitted to a nursing home or hospital; or the patient died.

DEMAND GROWS

Although we knew that in many situations the public health nurse's care needed to be supplemented, we could not predict the number of home health aides we would require. Consequently, the home health aides were employed as the services developed. At the end of the one and one-half year experimental period, we had seven full-time and 11 part-time home health aides on our staff. They gave service to 135 individuals, six of whom were readmitted to service during the project life.

Three patients received service for only four hours; one expired soon after the home health aide entered the home; one senile patient was suspicious that the family was plotting against her by using the home health aide; one patient was awaiting nursing home placement and no more than four hours of service had been planned. The greatest number of hours spent in any one situation was 478, the equivalent of not quite 12 weeks of service.

In testing the feasibility of the conditions originally set for closure of service, we found that 11 per cent of the patients were rehabilitated to an adequate level of self-care or family help. In an additional 36 per cent of the situations, the crisis was resolved to the point where members of the family, with the assistance of the public health nurse, were able to carry on. Therefore, in 47 per cent of the cases, the family had successfully "graduated" from the need for special services. Thirty-three per cent of the patients were eventually sent to a nursing home or hospital; here the home health aide's presence enabled the family to cope with the evident stresses of the waiting period.

Eighteen per cent of the patients died at home. We are convinced that some of them would have died in the hospital if there had not been an aide in the home to assist and support the family.

COST OF SERVICE

In October, 1962, the administrative staff of Community Nursing Services, with approval from the board, agreed to set the fee for home health aide service at $12.50 for an 8-hour day and $6.25 for a 3- to 4-hour day. These figures were derived from the salaried and fringe benefits, including Social Security and pension paid to the aide. The program's administrative overhead was not added since it would have made the costs for home health aide service higher than the current area rate for practical nurses. Computation of costs at the end of the project provided us with a rate of $2.35 an hour, or an actual cost of $18.80 for an 8-hour day of service.

If a patient could pay only a partial fee, the money was applied first against the cost of public health nursing service. Any remainder was allocated to the home health aide program. It was anticipated from the beginning that the cost for service to the majority of patients would have to be subsidized. This prediction has been substantiated, as most of the patients were on a very limited income.

Total income from all patients was $1,207.50 for the project period; 122 patients received free service; 11 paid a small part of the cost; one paid the full cost; and one paid full cost of $300 through the benefits of a health insurance plan.

Late in April, 1964, it seemed that we had reached the end of the program despite our conviction of its value. The contract with the Division of Chronic Diseases had been for a tooling-up period, and the Division had no funds for the extension. Community Nursing Services had no voluntary funds to continue the service over an extended period. The American Cancer Society, Philadelphia Division, and the Heart Association of Southeastern Pennsylvania were both involved in their campaigns to raise funds for 1964-65. Despite their belief that the home health aide services should be continued, they could only imply assistance in the future -- if they achieved campaign goals.

The project director, through the Philadelphia Health Research Fund, applied to the Commonwealth of Pennsylvania, and received a special grant of $5,000 to cover salaries and fringe benefits for seven aides and a nurse supervisor. The money was to be expended within the period of May 1, 1964, to June 30, 1964, for a special study on "Auxiliary Home Care Services to Patients with Cardiac and Other Chronic Diseases."

The community's conviction of the program's worth had its finest expression just when hope was dimmest. Through the activities of the board of directors of Community Nursing Services, the commissioner of health, and the managing director's office, an opportunity was found to present the need for the program to the mayor of Philadelphia. It was the mayor who directed that funds be found for employment of ten full-time home health aides and that this program be considered the city's responsibility.

Ten home health aides were placed on the city payroll in July, 1964. The Visiting Nurse Society provided Community Nursing Services with special funds for the salary of a supervisor.

In belief that these services should be supported by voluntary as well as tax funds, we tabulated data on source of income, health insurance, and age of patient. Thirty-seven patients had some Blue Cross coverage; six had other types of health insurance. The Medical Assistance to the Aged program paid hospitalization and nursing service for four patients.

These data led us to believe that we should approach Blue Cross on making this service available to policy holders. Negotiations have been started.

We conferred also with the state department of welfare, inasmuch as this agency has accepted responsibility for the indigent and medically indigent. Effective January, 1965, provisions were made for partial payment for home health aide service to indigent patients. Payments for services to Medical Assistance to Aged patients are being discussed.

A review of patients admitted to service by diagnosis showed that neoplasms ranked first, accounting for 28 per cent of the total. With preliminary data in hand, we approached the Southeastern Chapter of Pennsylvania Cancer Society and, as a 1964 Christmas gift, they contributed $2,000 to assist in paying for services to patients with cancer.

SUCCESS STORY

We have found to our satisfaction that the community can furnish trainable nonprofessional women to assist public health nurses in situations where the nurse alone could not effectively give the necessary service. This is a success story of people. It is their experience which appraises its worth. But it is not only the experience of people served; it is also the experience of a staff whose imagination was caught by an idea of service.

With ten home health aides on our permanent staff, it is possible to extend our efforts into the future with expansion plans that will seek both voluntary and official support. We now can test wider roles for home health aides beyond the care of the ill, but within the framework of a team with the public health nurse as the leader.

Future success will depend on the realization that we are dealing with changing problems in a continuously changing environment. This implies a willingness to forego traditional patterns of organization and truly experiment on behalf of the patient and his family.

VIII TRAINING AND USE OF HOME HEALTH AIDES*

IONE CAREY
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Certain provisions in Medicare recognize that many disabled persons can be cared for effectively at home if appropriate help is available. Appropriate help means the services of nurses, physicians, social workers, or other professional workers, depending on the needs of the patient. But also necessary in many situations is help for the families of patients.

If we are to maintain our aged at home, prevent or delay hospitalization, and allow for early discharge from nursing homes and hospitals, we must provide not just the services of professional workers for the patient but services that a family member would perform if a member were available. Even if an aged patient does not live alone, an aged partner, or grown children who are out of the home during the day may not be able to provide these services. Substituting for the family's services is an important part of home health aide service.

While nursing is an essential component of home care services, we know that two out of five persons in our population live in areas where no agency provides nursing care in homes. Also, there is a national shortage of employed nurses.

Two avenues for at least partial answers seem apparent. One is to find more inactive nurses interested in refresher courses and at least part-time work under supervision. The second is to expand the use of auxiliary personnel.

With the increasing number of nursing functions and programs, registered professional nurses have recognized that changes in patterns of staffing are clearly indicated. One of those changes is to delegate to properly trained assistants (licensed practical nurses and aides) those tasks that do not require the preparation and judgment of a registered professional nurse. In visiting nurse services, licensed practical nurses have long been employed.

A more recent development is the employment of home health aides to assist patients and families with much-needed, simple personal care. Home health aides, properly selected, trained, and supervised, can relieve professional nurses of duties that do not require their skills in caring for patients at home. In addition, aides can perform those selected but necessary duties that absent or incapacitated family members would do.

AIDES' DUTIES

What is a home health aide? What is her relationship to nursing? The aide is an unlicensed, nonprofessional worker, specifically oriented to the health needs of individuals and families. In our agency, we concentrate on the needs of the chronically ill and aged. An aide works in the home under the guidance and supervision of a registered professional nurse. Her role is a supportive one in nursing, and cannot be a substitute for the service of the nurse. It is the registered professional nurse who is responsible for guiding and supervising the home health aide. It is up to her to see that any therapeutic activity performed is safe for both the aide and the patient.

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* This paper was published in the American Journal of Nursing, August 1966-Volume 66, No. 8 and reprinted here with their permission.

During the past three years, the Visiting Nurse Service of New York, under a Community Health Facilities Act grant, demonstrated how visiting home aide service to the chronically ill and aged could be provided as an adjunct to nursing service. This service was provided in Queens, one of three city boroughs serviced by the agency. Now we are extending home health aide service to the other two boroughs.

The pattern we have established is only one way of providing such service. Such factors as needs of the community, availability of personnel, agency policies, and transportation help to determine how aides are trained and used.

Before determining whom to select as home health aides and how to train them, the aides' specific duties must be delineated. This is essential for the aides, the nursing staff, and the public. Administration must identify what is meant by the often-repeated phrase, the aide "assists with personal care and light housekeeping activities." Because home situations differ, the aide's duties must be adjusted to the particular patient and family situation. The typical types of assistance we see home health aides giving are: personal care of patients, meal preparation, routine housekeeping, and light laundry.

As instructed by the visiting nurse, the home health aide provides assistance with feeding, bathing, toileting, and dressing the patient. She helps the patient maintain range of motion, move from his bed to a chair or a toilet, and walk with canes, crutches, or a walkerette. She promotes the patient's independence in activities of daily living and she may, with a nurse's permission, take the patient outdoors.

Home health aides help plan for nutritious meals, do the shopping, and prepare meals, including specially prescribed diets.

Home health aides make beds, dust and vacuum, wash and dry dishes, and keep the bathroom and kitchen clean. They assist in such routine details of running a home, as defrosting a refrigerator or checking the laundry to send out.

Home health aides launder hosiery, undergarments, and night clothes. If there is a washing machine in the home or a nearby laundromat, other laundry can be done. They iron for patients, but do not iron heavy items -- sheets and the like.

RECRUITING AIDES

At the time we were ready to recruit aides in 1963 for our demonstration project, the 42-day newspaper strike in New York City had just begun. We had planned to advertise through the papers. Now as we look back, we believe that lack of newspaper advertising actually saved us difficulties. We would have been deluged with calls. And yet, in small suburban areas, newspaper advertisements might be helpful. To recruit, we went directly to our staff, the New York City Department of Health, and to the New York State Employment Service. Other sources might be physicians and community agencies. Now, we find that presently employed home health aides are our best source of new recruits. In recruiting aides some thought should be given to where they live and the problems of travel. Now that we are extending our program, we are not able to hire aides who live in Queens to work in some of the other areas the agency covers. Although they know the program well, travel time would be excessive.

Important in the successful recruitment of home health aides is the establishment of sound personnel policies. At the beginning of our project, we assumed that aides would be employed on a part-time basis, would be paid at an hourly rate, and would have workmen's compensation, disability insurance, and social security benefits. We soon learned that most of the women we recruited needed and wanted full-time employment. Lack of a guaranteed salary was a deterrent to recruitment. Now, personnel policies for our aides parallel those of other employees of the Visiting Nurse Service of New York: an annual salary, paid holidays, vacation, and sick time in addition to the previously mentioned benefits. They continue to have paid pre-employment physical examinations and to share the cost of their annual physical examinations.

Our experience has shown that an aide's previous work experience or the amount of her formal education are not the principal criteria to use in selecting home health aides. We have aides who have completed high school and a few who have only sixth- or eighth-grade education. Some of our best aides are in each group. Age may be one factor to consider, but our experience is limited. Most of our aides are between the ages of 40 and 59. An aide in her early twenties may be too inexperienced to cope with the many social and emotional problems that are usually encountered while assisting chronically ill and aged persons. However, we have not worked with sufficient numbers of aides in their early twenties to make a definitive statement about this.

SELECTION

In selecting the home health aide, the initial interview is of utmost importance. At this time we try to assess several characteristics: what type of personality does she have, is she outgoing, somewhat shy, or talkative? Can she read, write, and understand English? Does she seem interested in people? What is her background, her previous work experience? What is her personal appearance? Was she prompt?

As we continue to work closely with her, we are better able to judge whether or not she is flexible and tolerant of others; whether or not she has the ability to learn through demonstration and discussion; if she is an accurate, casual observer, and what her reactions are to doing housework.

Although aides are selected as carefully as possible, we know that some will be more successful in one type of situation than another. Who does what best and for whom is something we, as employers, need to learn. To assist in the evaluation of aides, we have devised a form which is reproduced with this article.* The nurse, who works closely with the aide and is responsible for the specific patient, completes this form at specified intervals. Written evaluations of newly employed aides are completed at the end of two weeks, six weeks, three months, and at three month intervals during the aides' first year; thereafter, twice a year. In addition, each home health aide is continually evaluated as she participates in such activities as on-going educational and team conferences.

TRAINING

Careful thought must be given to the training program for home health aides. While they should not be over-educated, they need sufficient help on a continuous basis to enable them to function efficiently and effectively. From time to time, we have changed our training program, as we gained experience in the use of home health aides.

Our present training program for aides includes orientation conferences and an inservice program. The orientation conferences consist of 20 hours of formal sessions within six to eight weeks of an aide's initial work assignment. We have experimented also with having aides complete these conferences before going into homes. We find that, with the former plan, aides participate more in discussions and find the sessions more meaningful. This, however, may not be feasible in some agencies due to travel, unavailability of teaching staff, and so forth.

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* Form at close of article.

Subjects included in these conferences are: orientation to the agency, given by the director of the aide program; working with people, given by the social work consultant; care of the chronically ill and aged, given by the rehabilitation consultant; home management, given by the nutrition consultant; and introduction to patient care, given by a public health nurse.

The most recent change in this list has been to eliminate the conference with the rehabilitation consultant and to incorporate some of this content into the session on introduction to patient care. We find that it is best to have the nurse demonstrate transfer activities and use of appliances at the individual patient's bedside in cooperation with the rehabilitation or physical therapy consultant. Our mental health consultant will give the class formerly given by the social work consultant, who was a member of the project staff.

The planned inservice training covers three areas. The first is individual demonstration, supervision, and guidance within the home in the area of personal care. Individual conferences are the second area. These are held at the local district office when the aide and the nurse or nurses with whom she works meet to discuss the progress of the patients or aide or both and to share information. These conferences add greatly to the aides' morale and strengthen the relationship between the aides and the nurses. Aides are instructed to telephone the nurse or supervisor when needs arise.

Group conferences make up the third area of inservice training. Aides are seen in groups of 15 to 20, approximately every three months. The agenda for these meetings vary, depending on the need. Sometimes they include discussion, and evaluation of orientation conferences, revision of aides' report forms, and use of case discussions to emphasize and clarify the role of the aide. We will develop this area further as we extend the program throughout the agency.

FAMILIES' ELIGIBILITY

A home health aide is assigned to a patient and family when, in the nurse's judgment, some of the personal care needs of her patient can be met safely by a nonprofessional worker. The registered professional nurse is still responsible for her patient and makes the decision to place the home health aide as part of her nursing care plan. Criteria for selecting patients should be developed as a guide to the nurse in assessing her patients' needs.

The nurse assesses the need for home health aide service and discusses this with her supervisor before placement of the aide is made.

The conditions under which home health aide service may be provided are: one or more members of the family are aged or chronically ill; the patient and family are willing to have the aide; the patient can be cared for safely at home, if he has some part-time assistance from a home aide (except in unusual situations, the maximum amount of aide service than can be provided in one week is 15 to 20 hours); the patient's physician is willing to have such service for his patient; the patient needs assistance with personal care and housekeeping activities; the primary need, however, is for personal care; no family member is available to give the assistance needed, or the family member who usually gives assistance is ill or incapacitated; and finally, a responsible person is available to work with the agency. (This person can be the patient.)

Priorities are given first to patients with potential for rehabilitation. Also given priority are patients living alone all or part of the day, who need assistance with personal care and housekeeping to enable them to remain safely in their homes and thus delay or prevent hospitalization or institutional placement. A third priority consideration is the need for temporary relief for a family, with a patient who has a chronic illness.

EVALUATION

Every case in which a patient receives home health aide service is carefully re-evaluated by the nurse and her supervisor at least every six weeks.

No time limit is set for the length of service to be given. Nurses stress with both physicians and families that home health aide placement is based on the needs of the patient and availability of personnel. Changes are needed from time to time to provide the best possible care to all patients in their own homes. The present fee for home health aide service is $2.80 per hour. (The average visit lasts 4.5 hours.) The policy regarding payment for aide assistance, like that for the visiting nurse, is based on the patient's ability to pay.

To help the nurse in her assessment of the patient's needs in terms of the criteria just described, we have developed a patient evaluation form. On this form the nurse notes the reasons for aide placement, condition of the patient, personal care to be given and household activities to be performed by the aide, the minimum amount of time needed, comments of the physician and family, and arrangements for payment.

Careful selection and training of aides, criteria for case selection, various tools to aid nurses in assessing patient needs - all are in vain without proper supervision of the home health aides. Supervision is the key to the success of working with home health aides. As nurses we are delegating certain personal care services to aides. Yet, we are legally and morally responsible for the safety of their activities for patients. It follows logically that staff must be prepared for this responsibility. Plans must be made and time allowed for orienting professional nursing staff on a continuous basis to (1) their role and responsibility for supervision, guidance, and evaluation of the aides, and (2) the need for continuous evaluation of each patient's and family's need for aide service. In the Visiting Nurse Service of New York, we have used both individual and group conferences with the field, supervisory, and administrative staff to orient professional nurses to this role and responsibility. The willingness of all to share ideas, opinions, and problems as they arise has been of great help in the development of the home health aide program.

The employment of home health aides can help provide quality care for patients with long-term illness and, at the same time, make it possible for nurses to use their skills in a broader and more effective way. We must be flexible and willing to experiment with one goal in mind -- better care for patients and families who will benefit from this service in their homes.

Home Aide Mrs. B. J.

Assigned Family Mrs. N. Mc G.

Date of Evaluation ____________________

Address H. A.

Date Aide Assigned ____________________

This evaluation report is made from the staff nurse's observation of the home aide's services and are summarized as follows:

I. Personal Qualities

Personal Appearance - Mrs. J. is always neatly groomed, clean and makes a very fine appearance in and out of uniform.

Punctuality - As far as I know, she has always been prompt whether she comes to the office or goes to the patient's home. Notifies family if she will be late, etc.

Sense of Responsibility - This aide takes her job very seriously. She senses her responsibility for patient care and carries out the plan for patient care to the greatest degree.

Initiative and Judgement - The nurse barely has to mention something to Mrs. J. and she carries it out immediately (getting patient OOB, positioning in bed, etc.) Always she uses excellent judgement in positioning patient and in urging patient to do more for herself. She also benefits from suggestions of our physical therapist.

Personality - This aide has the brightest, most cheerful outlook of any aide I have ever encountered. She is so warm that, she gives me a lift everytime I see her. Imagine what she does for the patient! (they love her!)

II. Relationship of aide to family/and staff nurse - Mrs. J. is very understanding of the seriousness of Mrs. Mc G. illness (she is a patient who was allowed to remain in bed following her accident and whose condition deteriorates because of this). Mrs. J. realizes the importance of her role in keeping the patient from regressing. She knows the stress the patient and her sister are under. The time she spends with the patient is well-used!

III. What is your opinion of her ability to perform home nursing and housekeeping tasks? (Include nursing care demonstrated and observed.) - With this patient, we have been trying to rehabilitate her to the point of minimal dependence on her sister. The patient is 86, her sister a few years younger, and we don't know how far she will go. However, she has improved remarkably since Mrs. J. is with her. I have demonstrated getting patient OOB, use of walker, positioning of patient, getting patient into wheel-chair, etc., plus exercise which Mrs. J. watches and encourages patient to do. All her care here is patient oriented, with very little housework. It is an ideal situation, and Mrs. J. is doing an ideal job. Progress is slow, but it is there.

IV. Remarks and/or Recommendations - Words cannot describe the really wonderful job Mrs. J. is doing here. The patient can now sit by herself, turn over, stand with the walker, bend her leg, etc., all because of Mrs. J.'s encouragement and constant attention. She is even walking with the walker. Needless to say, at her age, this is quite an accomplishment and Mrs. J. deserves much of the credit. We hope she can continue in this situation, and perhaps be able to reduce her time and eventually leave as patient improves.

Signature of Nurse ____________________

Signature of Supervisor ____________________

V. N. Evaluation of Aide
VNSNY Rev. 1966
Form 50-20-80

USE OF THIS FORM aids the registered nurse in charge of the patient in evaluating the aide's work. The nurse's comments, reproduced here, are taken from a typical record.

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IX HOMEMAKER SERVICE TO THE SINGLE-PARENT FAMILY*

ELIZABETH A. STRINGER
Director, Foster Care Services
The Children's Aid Society, New York

Although a family has been traditionally defined as a unit composed of two parents and one or more children, in recent years there has been a sharp increase in the number of one-parent families. The caseload of social agencies reflect this increase and the need for services to a parent who is struggling alone to maintain a home for the children.

In 1967 Homemaker Service of the Children's Aid Society served 138 families; 27 of these were headed by single parents. The term single parent is used for unmarried mothers and for parents who have been widowed, divorced, or separated. The single parent who received homemaker service included four widows, two widowers, one divorcee, five unmarried mothers, ten parents who were separated from their spouses, and four whose marital status was unverified. In addition, homemaker service was provided for one family in which the mother was deceased, the father was in jail, and the paternal grandmother was maintaining the home. The use of this service enabled 109 children to remain in their own homes during periods when parents were faced with illness or some other crisis that would otherwise have propelled the children into placement in foster homes.

The New York City Department of Welfare Homemaking Center referred seventeen of these families to our agency, eleven of them in need of twenty-four-hour service. Requests for service were made directly by eight parents, and one request was made by neighbors. One referral was made by another branch of the Children's Aid Society. Services were needed for reasons that fall into two general categories: a mother was physically ill, mentally ill, or recently deceased; or a child was ill, and the mother could not take time off from work or vocational training to spend the full day with the child.

WORKING MOTHERS

In general, the Children's Aid Society does not undertake to give homemaker service to working mothers or to mothers who are receiving vocational training. The agency's policy of giving high priority to children who otherwise would have to be placed in foster homes has precluded giving the long-term service working mothers usually require. But when the need is obviously temporary and the request is otherwise valid, service can be provided, as is illustrated in the case of Mrs. L.

> Mr. and Mrs. L had been separated for three years. Both were in their early forties. Their married life had been turbulent for many years because Mr. L. drank excessively and was unable to use help in overcoming his problems. When the parents separated, their sixteen-year-old daughter went to live with Mr. L and his mother, and Mrs. L kept their two sons, fourteen and five years of age. Mr. L could not accept the separation and tried to bribe the children to plead with their mother to take him back. Finally Mrs. L. obtained a court order to restrain him from interfering.

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* This paper was published in Social Casework, Vol. 48, No. 2 (February 1967), pp. 75-79. Permission to reproduce this paper was granted by the Editor, Family Service Association of America.

Mrs. L had a responsible position and supported herself and her sons on her salary and an additional $30 a week that she received from Mr. L. When plastic surgery was required to correct her younger son's congenital deformity, Mrs. L almost became ill herself wondering how she could leave her job for two months and still support her family. A homemaker kept the family intact until the child was able to resume his usual school and after-school routine.

The agency that had referred Mrs. L to us for homemaker service continued to provide intensive casework service to help her with the complex problems in her family situation. Our caseworker saw her to establish the details of service and the duties of the homemaker. The caseworker maintained contact with Mrs. L to keep in touch with the child's medical progress and to check on the effectiveness of the homemaker service. The caseworker also had weekly supervisory contact with the homemaker.

Homemaker service is enabling a divorced mother, Mrs. W, to complete a course of vocational study so that she may become self-supporting.

The W's were first known to the agency in 1959, when Mrs. W was awaiting admission to a mental hospital. Mr. and Mrs. W were in their thirties and were living together, although there was considerable tension in the home. Mr. W, too, was seriously emotionally disturbed. Their children, a two-year-old girl and a six-month-old boy, were in need of daily care while Mr. W worked. Homemaker service was given for six months -- during Mrs. W's hospitalization and after her return home. Mrs. W continued in psychiatric treatment, and Mr. W entered therapy. The marriage ultimately terminated in divorce.

Mrs. W was devoted to her children and they to her. She gave them excellent personal physical care, but she failed totally in her housekeeping. When Mrs. W. became overwhelmed with the responsibility of maintaining her household alone and was in serious danger of having to return to the hospital, homemaker service was again provided. In addition, on two occasions it was necessary for the agency to employ a male household worker to do heavy cleaning, which was beyond the scope of the homemaker's duties, and to help "dig out" the dirt.

Mrs. W. is a very intelligent woman who is motivated to succeed in a highly skilled course of vocational study in which she is now engaged. When she entered school, continuous homemaker service was provided. Mrs. W has maintained an A average. When she completes the course, she plans to employ a housekeeper while she works. Although Mrs. W's diagnosis is chronic schizophrenia, her ability to function as well as she is now doing is remarkable.

Mr. W contributes to the support of his children and continues to be an interested father.

Not unexpectedly, the children show evidence of emotional problems and have been referred to child guidance clinics. Because Mrs. W and her children are receiving casework and psychiatric service from another source, the role of our caseworker has been to establish the need for homemaker service, to determine the nature of the homemaker's duties, and to supervise the homemaker. The caseworker maintains contact with Mrs. W and the other agencies interested in the family in order to evaluate the effectiveness and validity of homemaker service.

THE DEATH OF THE MOTHER

In cases involving a mother's death, the father is given help through the period of shock and mourning, but he is expected to work out a long-range plan for the care of his children. The agency recognizes that it may take several years to work out a satisfactory plan when there are children under school age at the time of their mother's death.

> Mrs. N was in the terminal stage of cancer when Mr. N telephoned the agency for help. He could not admit the seriousness of her condition, even to himself. He called the worker again a few days later and sadly announced, "She couldn't make it." A homemaker has been placed with the family for almost a year. In his weekly sessions with the caseworker, Mr. N continues to say "we plan" or "we think."
>
> Mr. N is determined to keep his three sons with him, because of his own experience in childhood. He was ten years of age when his mother died, and he was reared by an aunt. His father subsequently married again and had another family. Mr. N thinks he will not remarry, since "no woman would want to be saddled with three small boys." Homemaker service will continue until all the boys are in school and suitable arrangements are worked out for their care after school.

Mr. S has a similar problem, although he has the assistance of his mother in caring for his children, who are two, three, and four years old.

> Mr. S is only twenty-two years old and has the responsibility of providing support and care for his young family. When his wife died several months ago after an acute illness, he gratefully accepted his widowed mother's offer to share her home with him and the children. She was separated from her own family when she was a child, and she does not want her grandchildren to have a similar experience if it can be avoided. She is in her forties and has a well-paying job. She is reluctant to leave the job because she believes her son will someday marry again and she will find it difficult to return to the labor market. Homemaker service is being provided during working hours until the caseworker can help Mr. S and his mother arrange day care for the children. The caseworker is helping Mr. S adjust to the loss of his young wife and help his three children.

ILLNESS

Thirteen single-parent families, whose functioning was disrupted by physical illness, surgery, or confinement, required only brief service. Eight of these required twenty-four-hour service for a period of time; for some, eight-hour service was necessary after the mother returned home and was convalescing. The length of service for these families ranged from seven days to seven weeks; the average was four weeks. In all thirteen cases, the homes appeared well-kept, and the children were cared for and emotionally stable. In two of the twenty-seven cases, the families were able to make a financial contribution toward the service; these were both cases of widowers.

Mental illness was the primary reason for the need for service in three cases. During the past five years, an increasing number of mothers has been able to return home from mental hospitals because drug therapy is continued. Homemaker service makes it possible for these mothers to resume functioning as parents through the encouragement and support provided by the homemaker and the caseworker. Another important advantage of this service is the caseworker's opportunity to evaluate the extent of the mother's recovery and to help the other members of the family who are seriously affected by the illness. In an article on the impact of parental hospitalization on children, Edward Schiff points out:

> Repeated clinical experiences have convincingly demonstrated one important fact: that the loss of a parent through hospitalization for mental illness always has a profound effect upon the child. The effect may be of long or relatively short duration or, just as important, delayed, depending on a variety of factors, not the lease of which are the child's age and state of ego development at the time the parent was hospitalized...Also significant is the removal of one parent and the ensuing disturbance often seen in the remaining parent; or the case of a parent who leaves, comes back, leaves again, and returns as a different person from the one the child knew before....
>
> This brings up a question of the utmost urgency. In these children under 5 (when the mother is out of the home, or in and out of the home and unable to care for the child), who will talk to the child and explain what is happening? Here the remaining parent needs help from social workers to cope with this problem.

Usually, temporary service is all that is needed to sustain the mentally ill mother through the initial impact caused by the return from the hospital and the resumption of her full responsibilities. The following case is one of the two that did not, however, have the usual favorable outcome.

> Mrs. K, a mother of four children ranging in age from one month to four years, was referred for service following the birth of her last baby. She had been separated from her husband for more than a year and needed help with the physical care of the children. She had a long history of mental disturbance. During the two months in which homemaker service was given, Mrs. K became increasingly agitated. The homemaker described to the caseworker the mother's sudden bursts of laughter and inappropriate singing, her thoughts that neighbors were spying on her, and her threats to kill the children. When these observations were shared with the referring agency, it was learned that Mrs. K had asked them for placement of her children. Although plans were in progress, Mrs. K was unable to endure the delay and, before the arrival of the homemaker one morning, she took her children to the welfare center and then disappeared.

UNMARRIED MOTHERS

In five of the twenty-seven cases, service was given to unmarried mothers; in a few other cases, service was provided for families in which one child or more had been born after the mothers had been separated from their husbands for a number of years. With only two exceptions, these families were functioning adequately, with no evidence of social problems other than the need for better housing and equipment. The children had been given stability, warmth, and more than adequate maternal care. Our observations correspond to the findings of a study conducted by Renee Berg of thirty unmarried mothers receiving public assistance:

> Although these mothers felt the burden of carrying sole responsibility for their children and living on an assistance grant, most of them used the money well, for nurture of their children and maintenance of their homes ... Although these mothers retain deviant mores about illegitimacy and one-parent families, their use of community resources and their strong desire for their children's educational and occupational advancement suggest that this is a group of transition, moving slowly toward increased acceptance of community standards.

In only two cases was there gross pathology in the family that required the removal of the children. In one of these, placement of the children was precipitated by the death of their mother. The children were subsequently relocated in the home of relatives in the South.

> One year prior to the referral for homemaker service, Miss B had given birth. At the same time, the doctors discovered that she was in an advanced stage of cancer. Twenty-four-hour homemaker service was arranged for the care of eight children whose ages ranged from twelve months to eleven years. One month later Miss B died.
>
> Miss B's home was totally disorganized and filthy. She had been superintendent of the building, but she had allowed conditions to deteriorate because she had been physically unable to do the work. The caseworker accompanied the homemaker on the first visit to the home and found a pitiful scene of children huddled on worn blankets and mats in a dark, cold apartment. Roaches were everywhere, and the children amused themselves in the evening by watching the mice scamper around the kitchen floor.
>
> The scenes witnessed in the home by the children had been sexually stimulating. Even the five-year-old child and the seven-year-old child portrayed in their speech and behavior the most intimate of adult sexual acts. But in spite of exceedingly inadequate living conditions and the physical deprivations, the reports of relatives and the personalities of the children themselves indicated that Miss B had loved her children and had tried to care for them until she reached the point of physical collapse.
>
> After the mother's death, homemaker service was continued for two weeks to enable the referring agency to arrange for the placement of the children with relatives in another state.

A frightening and deplorable situation that was found to exist in another family compelled our caseworker to recommend immediate action to remove the children from the home.

> Miss H had eleven children, including two sets of twins. She was living with a man who was said to be the father of her two youngest children. She asked the public agency for eight-hour homemaker service to help care for the children during her confinement, but because the agency had no available homemaker, the Children's Aid Society accepted the case on a purchase-of-service plan.
>
> The man with whom Miss H lived was not working, and the homemaker reported that he was compulsive about cleaning the apartment, except for one small room that the children shared with a shephard dog who was never taken outside. The room was foul from the odor of dog excrement. The three-year-old twins were found crying pitifully, soaked in their own urine. The two oldest children were allowed to go out on errands, but the other children were not permitted to leave the room except when the man called one of them. The homemaker reported that on several occasions the man summoned a girl to the kitchen. When she obeyed, she would be heard to cry out and then return to the room displaying a fresh knife cut on the hand or arm. Sometimes bright red spots were visible on the girls' legs; they had been burned with a scorching hot pan or iron. The homemaker exerted every effort to protect the children and reported her observations in a telephone call each night to the caseworker for the few days that it took the referring agency to remove the children. Although there were corroborating reports from the school and health agencies, the homemaker's report left no doubt that these children were grossly neglected and in grave danger and that immediate removal from the home was imperative.

CONCLUSION

Increasingly, more and more homes in the United States are being maintained by one parent. The mobility of the present population means that often there are no relatives nearby who can assist a parent when a crisis develops. Homemaker service is invaluable for these families because it enables the lone parent to keep the home intact and to avoid the trauma caused by separation and placement of children. The usefulness of homemaker service to the single parent who is working or taking a vocational course of study in order to keep the family together has also been proved. As homemaker service programs develop throughout the country, it will become increasingly possible to maintain motherless homes or homes of working mothers over a span of years.

The practical service of the homemaker and the technical knowledge and skills of the caseworkers help strengthen families that would otherwise become disorganized. The casework's role is multifaceted and variable.

She determines the validity of the need for service and establishes the details of service and the duties of the homemaker in relation to the functions of the various members of the family. She evaluates the family's ongoing ability to use the service constructively through regular contacts, usually weekly, with the homemaker and one member of the family or more. When a family is not receiving casework service from another source, the caseworker establishes a relationship of suitable intensity to help the single parent with the inherent problems of attempting to fill dual roles with the children. The caseworker assists the children either directly or through the parent to handle their confusions, anxieties, and adjustments to the temporary or permanent absence of the other parent. Finally, the caseworker's professional skill is vitally essential in making the decision to withdraw service in those few situations where maintaining the home is no longer constructive.

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X THE USE OF HOMEMAKER SERVICE IN PRESERVING FAMILY LIFE*

BRAHNA TRAGER
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Very early one morning, in a city on the West Coast, two children were awakened by a policeman. They had been sleeping soundly alone in their two room flat, unaware that their mother had not come home. They were not often left in this way, but when they were they were not greatly concerned. A neighbor across the hall was within calling distance; it was not a particularly frightening situation. The policeman did not know about the neighbor, there was no reason why he should, and he told the children as gently as possible that their mother was dead. He saw that the flat was neat and clean and that whoever kept it had a hard time making ends meet. He asked the children about their father and the older child, who was eight, told him he had "left a long time ago," and that, the policeman knew, was a fairly common story in the neighborhood. So he helped the children dress the best way he could. He couldn't find the little girl's socks and she finally wore her brother's which made her shoes too tight for her.

The children then went to Juvenile Hall with the policeman, and there an institutional experience began for them which was not particularly unkind except that grieving children do not adapt very well to it. For one thing, they were separated. Since they were not infants, the little girl was assigned to the girls' quarters and her older brother to the boys'. They saw each other, of course. They simply no longer lived together.

Grieving, they were examined by a pediatrician; grieving, they were weighed and measured; grieving, they listened to the story of their mother's sudden death from the lips of a very kindly social worker. And grieving, they wondered what would become of them, as well they might, for all of the other boys and girls around them seemed to be in the same position as they.

They had a visiting teacher; attending their old school was a thing of the past. They would have liked some of their regular clothes from home and people kept saying that someone would get them, but somehow it was never done, and they wore the clothes that were given them there that other children had worn and that had been washed in the institution laundry. They went to court with the social worker and then came away again. The little boy quite inadvertently heard that he was in the "slow normal" group, although both his mother and his sister always led him to believe that he was quite smart.

Now this is all true and there's no way to make such a long story short. It has no ending yet. These children were eventually placed in an excellent foster home. But by that time the little girl had begun to cry easily and to be careful about the effect of what she did and said in a most unchildlike way; and the little boy became what is known as a "problem." He had the most violent temper tantrums, and he would have one over such things as whether he had strawberry ice cream for dinner instead of chocolate. The foster mother did not think his tantrums were due to his being a "slow normal" boy. As a matter of fact, she thought him quite smart too. She said it was understandable, but it made him hard to handle.

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* **Paper given at the Minnesota Welfare Association Annual Conference, March 16, 1965.**

At just about this same time, in a city of the East Coast a social worker was awakened by her telephone. This time, too, it was a policeman. He told her that three children were alone in a tenement room and that their mother was in the hospital. He described the room as filthy, infested with cockroaches, and he had not seen any food that looked edible. The social worker thought for a moment and on the basis that "such as it is, it is their home and familiar" told the policeman that a homemaker would arrive within the hour, complete with bed roll and money for food in the morning. And in the morning the social worker would go to the home and they would then decide what might be the best thing to do. I don't know that this story has an ending either, because on the evidence I'm not at all sure that either the social worker or the homemaker could make a paradise out of a slum. The homemaker probably had a good deal to offer the children in that situation since she happened to have spent a good deal of time in just such neighborhoods with just this kind of children and as a result she was what we might call "reality oriented." The best that could be said is that maintaining the status quo for a while did really give everyone a chance to plan.

Those of you who have come here to hear about the development and operation of a community homemaker program as a constructive part of services to the family are perhaps thinking that the little vignettes that I have just given could not normally be called the kind of situation in which a normal homemaker service might be expected to function. I will agree to this, but I think I would like to make the point at the outset that the conventional descriptions of homemaker programs - although they make an attractive package to sell to a community - do not represent the realities which such programs face, either. Those of us who have worked for some years in homemaker service must sadly admit that it is quite rare that we are asked to come into a family situation in which everything is normal in the relationship, in which the standards of living are somewhat middle-class or approaching middle-class, and in which temporary illness or dislocation threatens an already intact family life which we can protect and preserve with the simple addition of this one very good service. I say we rarely see it, although I admit that it occasionally does happen. But I am not going to talk about the preservation of this particular kind of family life today because I would like to take it for granted that the simple provision of such a service can be effective, and then let it go at that. What I would like to talk about are some of the realities in the broad range of situations which really are the daily fare of any homemaker service in an urban community with urban problems. And then I would like us to ask ourselves some questions which might perhaps serve to clarify where we think we are going, what we really hope to accomplish, and how we hope to accomplish it; and the how, of course, is a difficult business.

First of all, I think all of us will agree that, when we approach new programs which are intended to meet old problems, it is usually easier, or perhaps more comfortable, to accept a somewhat simplified approach. All of us have seen these over-simplifications which have beset social planning over the years. They are compounded of the desire to find a single solution by explaining the problem in a single way. Some of you, who have been in the field of social welfare as long as I, can remember that we came in perhaps at the tail end of the approach which classified disadvantaged people as psychologically inferior, unadjusted to their environment, and in need of what we used to call the "authoritative" or "manipulative" approach. I can remember reading old records in which the social worker felt very comfortable about asking a drinking man to take the pledge, to straighten up and take care of his family; and I can remember situations in which the giving or withholding of material help was based on people's willingness to do as they were told by other people who, because of their economic security, were presumed to know what was best. Some of this, I think, still does carry over into parts of our social welfare structure today. It expresses itself in a kind of social planning which still makes strong economic distinctions in the development of broad community services.

In social work, however, there is no question that this type of agressive management lost favor and that we saw a strong trend in the direction of considering all difficulties a function of adequate or inadequate ego strength. I can remember quite recently being involved in a collaborative case in which the key worker felt that it should not be her function to discuss what the client considered of prime importance. She was recently widowed and with small children. What she thought of as her first need was some kind of approach to planning on a limited budget. She was brought back, gently but firmly, by the worker to the point that she was there to explore her grief and the meaning of the deprivation in her life, and that a consideration of her financial situation at that point constituted a digression from the focus of the work to be done. I am really not saying this critically, but I did think that for a social worker it represented a rather extreme position and I myself felt no compunction about dealing with the budget which was genuinely a problem, thus relieving a particular kind of pressure and releasing a particular kind of energy which presumably could be channelled more constructively. I will even go farther than this and say that in situations where financing, with a lack of money, is a real problem, I sometimes wonder at the separation between the casework or therapy centered social worker's job and the job of that group of workers which seems to have been relegated to the welfare department and which for many of the family agencies, and indeed for many of the workers themselves, seems to have begun to occupy a somewhat inferior position.

In the same way, attitudes toward the care of children in crisis situations have had their fads and fashions. All of us have heard innumberable accounts of the good old days when kindly neighbors moved in and took over in situations of crisis so that agencies which were organized were virtually unnecessary. I sometimes think of these accounts in the same way that I listen to the stories about the old days when the grandmother or the grandfather was a revered member of the family, who was retired to a place of honor to be cared for and respected and to have his place by the fire and his rocking chair on the front porch. As a matter of fact, these stories are very much like the stories about homemaker service today as it is presented to the public: a cheerful service in a cheerful situation which makes everybody extremely happy because it is successful. Those good situations both for children and adults in the old days applied, then as they do today, to people who were relatively secure economically; and both literature and history are filled with the grim stories in our recent past of children and old people auctioned off to the lowest bidder or spending their lives in miserable poor farms. In professional thinking, however, changes have taken place which have made some significant changes in program. Again, I came into the field of social work at the tail end of what I can only call the glamorization of institutional care for children -- the era of brightly painted walls with attractive decals, fluttering curtains, a cottage plan, house mothers, toys, individual clothing allowances. During the war, however -- and probably as a result of Anna Freud's work with children bereft of families -- we began to see that many of these children grew up "lacking in affect" and the trend began to swing sharply in the other direction with social workers saying that, under any and all circumstances, home is best, and that children feel secure with even bad parents as opposed to "good people" in institutions. Perhaps recent studies of groups of battered children will begin again to inject some doubt into our convinced position, but I think we will all agree that most of us do not like to take children out of their homes, even for a brief period, unless it is absolutely necessary that the situations in which we might be expected to take children out of their homes are usually crisis situations so that we are doubly convinced that the trauma with all its implications for the future is compounded.

Much of this thinking, of course, has affected that development and trend in homemaker service throughout the country. I would distinguish this developmental process in the United States from the very large homemaker programs which exist in other countries, notably the United Kingdom, because I think that from the outset its planning here was motivated by ideological consideration rather than practical ones. We see it developing first in this country almost as an adjunct to maternity services; almost all of the early literature gives, as the typical example, the mother who must be hospitalized for confinement, with the homemaker coming in the home to make papa and the children comfortable until she returns home with the new baby and then seeing her through the early stages of being a (new) mother. All of this developed in opposition to the old practice of placing the children while the mother was out of the home. I suppose it is still true that homemakers are needed for this purpose. The shortening of institutional maternity care, however, must mean that this is a very brief service indeed, and in most communities the maternal and child health program of the health department provides at least some of the "tidying over" services.

Then we also see homemaker services developing in family agencies as a part of the "casework plan" and there is some evidence of agencies which provide homemaker service only as an adjunct to casework service. Indeed, in extreme instances, we have heard the interpretation -- inferred at least -- that any family in need of physical assistance in the home must, therefore, have problems which require casework assistance. Here I think the confusion arises from the definition of homemaker service as a "professionally supervised" service with, perhaps, some feeling that if we are going to use professional social workers we should use them to provide an intensive casework service. I am sure that there are situations when this kind of intensive service is very essential but, I think, on the other side the use of professional supervision has a very real general application. There is no need to embroider the point that the "family" and the "helper" meeting each other in what is almost invariably a crisis situation might require professional assistance of someone who understands the nature of crisis without making a problem of it.

Now we are seeing something else develop in this field again: the conception that we are going to cure the effects of long continued past and continuing present deprivation by using homemakers to raise "standards", and I sometimes have an uncomfortable feeling that, what we mean by that is, we hope for a middle class standard of living which will miraculously blossom in the mire of deprivation simply by sending in a nice lady with professional supervision to help in the home. It is at this point that I should like us to stop at least for a few minutes today and take a look at what it is we are after in homemaker service.

First of all, I think we need to take a look at the kind of family life we want to preserve and, here I think, many of us, who have looked at the conventional picture of homemaker service, are going to have to readjust our thinking. Because all of the time that we are hearing these same stories about the service and what it can do, people running homemaker programs are finding that it almost invariably is the multi-problem family or the multi-problem situation which is being referred to us: a mother substitute sent into a situation in which the financial resources are so limited that even minimum decency cannot be paid for; a household in which there is no money for soap, in which there is no money for heat, in which there is no money for light, in which there is no money for bedsheets, and in which the food budget has been computed by a trained home economist, perhaps, so that maximum nourishment could be purchased with it, given the fact that you had a college graduate to do the planning and purchasing. Such a mother substitute in such a situation is really not going to help much in preserving a sense of security in the family. Surveys and reports from homemaker agencies support the fact that more than 90 per cent of all of the referrals are made because of illness in the family; some of it crisis-type illness, much of it chronic; some of it physical, some of it mental, and some in combination. Now we all know that the provision of a homemaker even with professional supervision -- even though she may have been taught to do certain personal things for a sick member of the family -- is not going to be able to make up for the lack of good, organized, continuous, and available medical care.

The kind of homemaker service we offer, therefore, is going to be very much affected by the kind of community in which it exists; and at the same time that we develop our socially idealistic conception of homemaker service, we are, most of us, working in communities where there is the most extreme fragmentation. There is one level of service for the private agency and another level of service for the public agency. Within the public agency, there are different categories of services for different categories of people; there are different kinds of medical care available for different groups. I think there is no question but that the client group which it serves, to some extent, affects the kind of program which a given homemaker service will develop. I do not mean by this that we are orienting ourselves to meet the needs that we see in groups that we serve but that, rather, we tend to tailor our program to the economic level of the group that we serve: a cheaper program for the poor, a better program for the middle-class, and I will not say the best program for socially advantaged although I believe that homemaker service could serve them well. I say that it cannot be that good a program unless it has its roots in high standards of service at the very lowest level.

It is for this reason that I am somewhat concerned about the great popularity of homemaker programs in the Economic Opportunities Act planning. I have seen some communities in the past in which recipients of Aid to Dependent Children were sent into the homes of other recipients in order to earn enough to meet their budgets. Indeed I have worked with some of the women in this classification, using them as homemakers. I did not find, as I understand others have, that these women made poorer homemakers or needed any more training or help than any of our other homemakers, because when we screen for homemaker personnel in our agency we apply pretty much the same standards to everyone who is going to be a helping person in the home. What I did find, however, was that the employment and the training were purchased at a great sacrifice of the worker's own family life; that in the process of encouraging ADC mothers to take in each other's washing in order to be employed and to relieve the community of their support, we were ultimately heading into individual situations in which we were going to have to offer other kinds of community services to the homemaker who left her little children at home with inadequate care.

I have some other worries about the development of homemaker service which many of you have already shared, I am sure. And this has to do with the fact that the financing of the service is something that we have considered only in very compartmentalized ways. As yet, we have not developed the idea that a homemaker program should really be financed by the whole community to serve the whole communtiy. We know that welfare departments can have homemaker programs provided they meet certain requirements; and, as a rule, where these programs have been developed it has been to serve the welfare department's clientele. In the Public Assistance Medical Care (Kerr-Mills) legislation we see a special kind of financing for someone called a "Home Health Aide" who functions as an adjunct to medical care and this person, who is really a homemaker with the ability to do some personal services, is not intended to do housework at the same time or, at least, only that which is related to patient care so that presumably the rest of the household goes unassisted. We see private agencies developing homemaker services always under-financed and, therefore, very limited in scope in order to serve a particular client group; and now we will probably see homemaker service used as an avenue of training in the Economic Opportunities Act, but with the very real problem of under-employment at the other end of training; a cruel hope to hold out unless broad financing for homemaker programs is available.

I think at this point I should perhaps, after such rather discouraging comments, say to you that I think there is no single service that has recently been developed which has a greater potential than homemaker service and that it is capable of achieving successes far beyond what anybody has ever imagined. We have seen homemakers raise motherless children and do a wonderful job of it. We have seen homemakers help with a massively handicapped child, a mentally disturbed child, or a mentally disturbed mother with little children, in ways that are so infinitely understanding and compassionate that perhaps no other kind of personnel could possible have achieved such a climate in the home. We have seen homemakers working with a mentally confused, elderly person reduce that confusion to the point where the doctor's diagnosis of senility no longer applied because re-integration of the person in his familiar situation has really been the treatment needed. We have seen homemakers provide eyes and ears for the physician, the nurse, the social worker, psychiatrist, with a kind of carefulness of observation and continuity that can never be achieved in single home visits, office consultations, or even in institutional care.

These are individual miracles and I am certain that they occur in every homemaker plan. They occur most frequently, however, in homemaker programs which have their broadest base in the community; which have available other community services related to good care; and which have both a concern with the individual in his environment but which demonstrates equal concern for the quality of that environment. I think the kind of family life that we want to preserve in its particulars will differ from one family to another depending on a whole range of factors in the situation. Social workers are good at that kind of particularization, but they do the individual job best in an agency where financing does not exert pressures on policy; where termination of service on any basis other than the needs of the family is not a solution; where limitations in service do not pressure people into ways of life which are not constructive -- in other words, where there is not an imposition of criteria which stem from the categorization of groups of people, but rather a consideration of the broad needs of people in the community. There must be a general attitude of security and flexibility that comes of the realization that sometimes homemaker service is simply housework when there is too much to do and, other times, it is the most delicate part of case work help when the situation is complex.

Again, I say that we need to take a look at the kind of family life which we want to preserve. To me, family life at its best is an enabling thing--it enables people to do what Freud once said were the important things: to work and to love. But neither the creativity necessary for the one nor the awareness necessary for the other are well nurtured in poverty, despair and disintegration. It is certainly true that our institutions cannot eliminate any of the horrors that are a part of the human condition, but it does seem that we are still far behind in making the kind of courageous new approaches to the organization of our social institutions which could do a great deal to mitigate them. Homemaker service can only be as good as the community which supports it. At its best it will be a strong link in a chain of related sustaining and protective services; at its worst an apologetic facade for what should be there and isn't.

XI HOMEMAKERS FOR CHRONICALLY ILL AND AGED: A DESCRIPTION *

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Consider the headline potential of an 80-year-old woman lying alone for days on a mountaintop with a broken leg! Think of the headlines, the suspense, the minute-by-minute account of the rescue team's approach, the perilous descent by stretcher, the ambulance sirens clamoring down a highway, the escorting police on motorcycles, the hospital team waiting at the emergency entrance, the featured interview about the patient's ordeal in the newspaper, the pictures on TV of the sequence of events, the public sigh of relief that this valiant woman has been rescued and given succor, and life has been extended.

Yet here in a busy city in a busy neighborhood, no sirens sounded for a lone 80-year-old widow stranded with a broken leg -- in her own apartment. For three months, Mrs. W. had lain bedridden in crippling pain, without medical attention.

Occasionally a neighbor visited, a man delivered groceries, a friend called. But no effective aid reached Mrs. W. She herself thought her trouble was arthritis and that it was incurable. She could not afford a private doctor and, because of a bad experience with clinic care ten years ago (she had been left unattended for many painful hours), she would not go to a clinic. How are people like Mrs. W. to be rescued from their mountaintops of social isolation?

In Mrs. W's case, rescue was eventually effected by a caseworker and a homemaker who was assigned as part of a USPHS-supported demonstration-research project on homemaker service to the chronically ill and aged.

THE HOMEMAKER'S OBSERVATIONS

The following direct quotes from the homemaker's written observations about Mrs. W. tell the story:

8/14 -- Mrs. W. is a widow, living alone. She is constantly in pain. The caseworker and I talked with her about medical treatment. I went to the grocery store, fixed her some soup. I mopped the floor and did the dishes. I promised to return.

8/16 -- Mrs. W. in much pain when I arrived. I tried to get her mind off her misery. She has an immeasurable sense of humor. First, I washed the door so she would have something different to look at, the before and after; this gave her a big laugh. Then we began planning what to have for dinner. I mopped, cleaned stove, refrigerator, and cleaned her commode.

8/18 -- Mrs. W. in much pain when I arrived. Caseworker had appointment to take her to clinic. I gave her a sponge bath, placed her clothes where she could reach them to wear to the clinic. I

*** This this paper was published in The Gerontologist, Vol. 6, No. 3 (September 1966), pp. 150-153. Permission to reproduce this paper was granted by the Gerontological Society.**

put her necessities in her purse, placed shoes and socks by the bed. I told her how glad we were about her decision to go to clinic. I swept floor and washed dishes. She was concerned about her door key, two keys on ring, one for door, and one for closet, so I took nail polish and wrote "door" on door key. This satisfied her very much. It seems that these little things worry clients very much.

THE CLIENT'S REACTION

How did Mrs. W. feel about the homemaker service? In a letter she wrote: "I hate to think what would have happened to me without the caseworker and homemaker program. I am 80 years old and live alone and had broken my leg and did not know it."

Some months later, in an interview about her experience with homemaker service, Mrs. W. was asked what were the most important ways the homemaker helped her. Here is what she answered:

> She went with me to the hospital and knew what to do, how to behave, how to talk back to the doctor (sic!). Helps keep my room clean. I liked her very much and wish that she lived next door to me. She shops for me and does errands. She doesn't have to be told what to do or how to do it. She knows how to do. It's nice to have her visit.

THE DEMONSTRATION SERVED 167 FAMILIES

This case is one of 167 families served by the demonstration homemakers in the aforementioned project on homemaker service in chronically ill and aged. This three-year project, located in the Health and Welfare Council of Metropolitan St. Louis, placed six homemakers in four agencies: a public welfare agency, a department of aging of a voluntary casework agency, a public hospital home care program, and a voluntary visiting nursing agency. In three of these agencies the homemakers were supervised by casework staff and in one by nursing staff.

All cases were served on a part-time basis, but no limitation was placed on duration of service. The families consisted primarily of either single elderly persons or two elderly persons, of whom at least one was chronically ill. The two-person families were often married couples, but many were elderly mothers and daughters living together or elderly siblings.

The research design called for a semi-structured interview at the beginning of each new case. In addition to basic demographic information, the agency was asked about the person's family relationships, social engagement or isolation, medical diagnosis, physical and mental disabilities. Follow-ups were completed on each family which continued to be served at 3-, 9-, and 15-month intervals.

EMOTIONAL SUPPORT IMPORTANT

One of the questions asked on the initial assignment form was what the agencies hoped to gain by the placement of a homemaker. On the follow-up form, the agencies were asked what were the three most important ways the service had helped a family. While the answers to these questions are not fully comparable, it does seem important to comment on an apparent increase in the extent to which emotional support was mentioned after service had been given for a period of time.

Reasons for the variance in the response after service may include an initially more restricted view of the homemaker's role, such as considering her primarily in relation to housekeeping and not realizing her additonal help in boosting morale,socialization with the lonely, etc.

That the presence of the homemaker and her interaction with families is closely allied to the practical housekeeping functions is illustrated by the following: A recipient of service who had been particularly demanding (on the first visit she had, among other things, ordered the homemaker to wash the walls) was skipped for one time because the homemaker was sick. She called the agency to tell them how much she missed the homemaker, and then burst out: "I don't care if she ever cleans anything again -- I just want her to come!"

THE HOMEMAKERS SPEAK

The project's coded data show, in one way, how the homemakers met some of the expressed and unexpressed needs of clients. Another way to find out how they interact with the people they serve is to listen to what they themselves have to tell us about their experiences. The homemaker cited above recognized that "these little things worry clients very much." So did the one who told an aged eccentric who did not want to wear her new glasses: "You look so dignified with those glasses on."

And there was the homemaker who took Easter baskets around to several of her clients she knew were not much interested in eating. And the one who said of a recently widowed 75-year-old who did nothing but sit in his rocker and stare into space: "Someone has to let him know he is alive." And the one who said: "I made curtains so her room looked less like a prison cell." One homemaker seemed much like a Mary Poppins for adults when she said: "one day I asked Mrs. S. if she could sing. So I carried a tune. I had her join in and she did. I thought this might help her as she doesn't talk very much. A little tune now and then has its points."

THREE PREREQUISITES FOR A HOMEMAKER PROGRAM

Can the kind of sensitivity and awareness manifested in infinite variety by these demonstration homemakers be fostered in other homemaker programs? To accomplish this, three key prerequisites are suggested: 1) extremely careful selection, 2) adequate orientation of agency staff to the contribution homemakers can make, and 3) supervision which recognizes and stimulates homemakers to use, within the framework of agency operation and function, their own original and spontaneous judgment.

SELECTING HOMEMAKERS

A total of 144 applicants were interviewed during the project. Of these, 46 were recommended for jobs as homemakers. Since one of the aims of the project was to demonstrate centralized recruitment, selection, and training, homemakers recommended by the project were hired by community agencies and programs other than the four in the demonstration. In all, 35 homemakers were actually placed, including the six working for the demonstration agencies.

QUALITIES LOOKED FOR IN SELECTION INTERVIEW

In addition to factual information about the applicant, a number of other qualities were sought during the selection interview. Each person was given a detailed description of the nature of the homemaker's job and its agency relationship. The applicant's feelings about this type of employment were explored with her. Her ability to grasp the various aspects of the job, her attitudes toward this kind of work, her responsiveness to it, and the kinds of questions she asked were all significant in the selection.

Also looked for were such characteristics as warmth, spontaneity, flexibility, ability to relate to interviewer and in what manner, ability to articulate feelings, ability to communicate verbally and non-verbally, feelings about parents and siblings, feelings about own children and ability to individualize them and accept differences, attitudes toward spouse, previous capacity to reach out in own neighborhood and community as evidenced by church work, volunteer, or neighborhood activity, and attitudes toward previous work situations.

The reasons for rejection were many times the negative aspects of these factors: inability to articulate, lack of responsiveness, inability to communicate, apathy, continuous marital difficulties, withdrawal from own family or children or lack of gratification in relationships with own family or children, a history of social isolation, mental limitations, history of emotional disturbance, preference for another type of work, viewing the job as loss of status to herself or her family, rigidity, religious fanaticism.

ORIENTATION OF STAFF: FIVE ASPECTS

Preparation of agency staff is essential to the successful operation of any homemaker program. Some important aspects in the orientation and training of staff, whether they be caseworkers or nurses, include:

1) Over-all understanding by staff members of the homemaker's role and function and their appropriate role in relation to her;

2) Recognition of which situations are appropriate for homemaker service (and in accord with stated agency policy) and which are not, so that suitable referrals can be made;

3) Proper preparation of both recipient and homemaker so that the extent and limitations of the homemaker's duties are clear to all;

4) Definite enunciation and demarcation of staff roles in relation to the homemaker and the homemaker supervisor;

5) Structuring of a communication system to include supervisor, other staff, and homemaker. (This will vary by agency according to its own particular set-up. The conference method has proved to be most successful in the demonstration agencies.)

Both homemaker and professional staff function more securely when their relationship to each other is precisely spelled out. By the same token, the family and homemaker function more securely and conflict is reduced to a minimum when both are adequately prepared and when each understands the extent -- as well as the limits -- of the other's responsibilities and duties.

AN ATMOSPHERE OF FREEDOM

A staff which is aware of the breadth of possible uses of homemaker service will demonstrate considerable ingenuity and flexibility in its utilization of homemakers, and homemakers working in such an atmosphere of freedom can, as shown earlier, display a remarkable flair in interpersonal relationships.

David (1960), of the U.S. Public Health Service, stated this concept well when he said: "Let us not view the homemaker as a hazardous radiation exposure in our midst, on which rigid limits must be imposed. Instead, let us view her as a source of a particular kind of service whose benefit will be cumulative throughout our society."

GOOD SUPERVISION A STIMULANT TO HOMEMAKERS

The homemaker's intergration into an agency as a staff member is facilitated by a climate of acceptance created by a well-oriented professional staff. In addition, good supervision promotes the homemaker's own growth and development on the job. As in all learning experiences, praise and recognition for a resourceful solution in an emergency, or for success in, say, helping to motivate to eat or to get out of bed encourages and stimulates the homemaker in her work.

The good supervisor will allow the homemaker to give full reign to her natural and intuitive sympathies, to feel empathy, and to increase her observations, which are so valuable diagnostically to an agency.

Problems of illness, social disorganization, family conflict, poverty, and discouragement plague many of the families served by homemakers. It is important that supervisors be aware of the contagious nature of the depression and anxiety found in these families which may, in turn, affect the homemakers who spend many hours every day in this kind of environment. Means must be ever available to counteract these deterrants to the high morale, courage, and optimism which characterize homemakers at their best. Because she spends so much time in the home, the homemaker is the chief line of communication with the family. By the very act of being assigned to serve in a home, the homemaker is given the responsibility to interact with members of the family. Natural spontaneity cannot be induced by instruction nor can a supervisor expect to be on hand to censure acts of behavior or speech of which she does not approve. But broad guidance can be given to the homemaker, and goals can be identified and shared.

SUMMARY

To achieve maximum benefit from the uniquely practical and human benefits of homemaker service, experience on a project for homemaker service to chronically ill and aged suggests three prerequisites: 1) careful selection, 2) adequate orientation of agency staff, and 3) supervision which promotes the growth and development of the homemaker.

It is unrealistic to assume that homemakers or home health aides will spend hours in a family performing tasks only mechanically, whether it be sweeping the floor or giving personal care.

Our task is to make sure that these relationships promote constructive ends, that we avoid exploitive, damaging, or negative experiences for families. It is the contention of this article that it is possible, through homemaker service, to design and furnish service which promotes what Tillich (1962) has called "the law of listening love" which "... listens sensitively and reacts spontaneaously."

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XII HOMEMAKER SERVICE IN PSYCHIATRIC REHABILITATION*

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INTRODUCTION

Although an emotional illness presents problems of adaptation to members of the patient's family in any circumstances, the problems are most disturbing and far-reaching in their effects on family solidarity when the patient is the mother of young or adolescent children. Children inevitably suffer from separation and loss of maternal support whenever a mother is hospitalized for any reason, but when the mother is mentally ill the children must also cope with their own concept of mental illness: i.e., a condition which to them is certainly mysterious, perhaps shameful, and often treated by friends or schoolmates with derision. Moreover, during the early phases of her illness, the mother's attitudes or actions may have estranged or frightened the children. As a result, the children often develop ambivalent feelings, which are followed by guilt and self-condemnation when the mother leaves for the hospital.

> Cheryl, aged 6, had been a reasonably well-adjusted child before her mother was committed to a state hospital for treatment of paranoid schizophrenia. Shortly thereafter Cheryl was reported to be "wistful and clinging, wondering if mother had gone to the hospital to have another baby. She worries constantly, thinks she is naughty and wishes she could go to heaven. She repeatedly asks: 'I have been a good girl today, haven't I?'

The patient's husband may experience ambivalence, anxiety, shame, guilt, and estrangement, which lead to preoccupation with his own reactions and an inability even to give the emotional support he customarily offers his children, to say nothing of the added comfort they require at this time. Although the husband may receive casework help in understanding his wife's illness as part of the psychiatric treatment program, the caseworker usually focuses primarily on the interaction between the patient and the rest of the family, and gives secondary consideration to the day-to-day problems of the children.

Care of the children is most often assigned to relatives, who may or may not welcome the opportunity. If the plan requires the children to move out of their home, it usually means the loss of many of their sources of security: father, friends, school, and familiar surroundings. If the children are distributed among various relatives they lose the security of each other's presence. When a relative moves into the house to take over the children's care, consequent tensions within the family may complicate the picture.

Families without available relatives try various alternatives, none of which is completely satisfactory. Housekeepers are hard to find, and prefer to avoid homes where children are upset; the patience of the neighbors wears thin; and there are serious psychological hazards in turning over the mother's responsibilities to an older daughter.

*** Paper given at 113th annual meeting of The American Psychiatric Association, Chicago, Illinois, May 15, 1967, published in American Journal of Psychiatry, Vol. 114, No. 11-May 1968, who have granted permission to reproduce.**

> When Mrs. C. was committed to a state hospital her 12-year-old daughter undertook the care of 3 younger siblings. In her new role in the home, she conferred with her father about domestic problems and the care of the children, and in other ways took over many of the responsibilities and prerogatives of a wife and mother. Superficially she appeared to enjoy the opportunity to take her mother's place, but at the same time her father noted that she had become anxious and apprehensive in her relationship to him, and that she complained of insomnia and nightmares, and that she had become unreasonably possessive of the baby.

When other alternatives fail, the father may be forced into placing the children in temporary foster homes, an experience which, however well carried out, cannot help but add another increment of insecurity for the children.

> When a young woman went to the hospital with schizophrenia, her husband, upset, depressed and unsure of himself, made rather precipitate plans for foster home care for their two children. The children, confused, perplexed and distressed, suffering from the double loss of both mother and father at the same time, attempted to establish some kind of relationship with the foster parents. Meanwhile the mother improved and returned home, but became very upset because the children were in the care of somebody else, and insisted on their return. Almost immediately thereafter she relapsed, and the whole pattern repeated itself.

DESCRIPTION OF HOMEMAKER AND SERVICE

In many communities a more satisfactory alternative is provided. One hundred twenty-eight social work agencies in this country provide homemaker service to care for children in their homes when the parental function is impaired. Homemakers are women who are part of the agency staff, who are trained and supervised by caseworkers, and who work primarily in homes where the mothers of young or adolescent children are temporarily and unavoidably absent. Homemakers are chosen for their interest in children, their ability to get along with people, and their homemaker skills. They usually have enjoyed family life and have been successful as parents of children who are now grown. Casework is an integral part of homemaker service; it is used both in determining its appropriateness for the particular family under consideration, and in helping the family to make the best use of the service and to work out associated problems.

Although originally developed to provide substitutes for mothers with physical illness, this program has found gradually increasing application in homes where the mother is suffering from mental illness. In some agencies more than a quarter of all the homemaker assignments involve cases of mental illness. To my knowledge, however, there is nothing in the psychiatric literature which describes it, and psychiatrists generally either do not know of its existence, or know too little of its nature and indications to work efficiently with the supplying agency. The optimal functioning of homemaker service in families where the mother is mentally ill depends to a major degree on familiarity of the psychiatrist with the extent and limitations of agency services as well as on familiarity of the agency with the treatment goals of the psychiatrist.

The object of this paper is to clarify homemaker service for the psychiatrist. Once psychiatrists know of its existence and understand its operation, I feel confident that they will find it a new and valuable adjunct in the treatment and rehabilitation of many of their patients. Furthermore, awareness of its potential value may encourage psychiatrists to use their considerable community influence to support its development and extension.

The material of the paper is derived from my experience over several years as psychiatric consultant for the Minneapolis Family and Children's Service, as participant in their training program for homemakers, and in collaborative work with the agency in a few cases where a mother of young children was my patient. My illustrations are drawn from the records of 16 cases which were presented at consultation seminars during a 4-year interval, and which were selected from over a hundred cases in which the agency participated in that period.

PREREQUISITES FOR HOMEMAKER SERVICE

Homemaker service is indicated for families in which the mother of young or adolescent children is mentally ill under the following 6 conditions:

1. If the father or other responsible adult is living in the home. This requirement is essential since it is impractical for social agencies to take full responsibility for families. Furthermore, the goal of homemaker service is the maintenance or reconstitution of the family; one of its major advantages over foster home placement lies in the fact that the father is kept in close contact with his children during the period of disruption caused by the mother's illness. His home and his children sustain him in his deprivation and may give him the support necessary for him to maintain the integrity of the home, which in turn makes it possible for the mother to return to familiar surroundings for her convalescence.

2. If the illness appears to be temporary, or during the period that plans for permanent care are being developed. Although the accepted limits of homemaker care have increased from a few weeks to a year or more, most agencies cannot yet undertake indefinite care. If it appears unlikely that the mother will ever return, an alternate plan, tailored to the specific needs and resources of the family, may be necessary. Often the agency may help the family work towards the development of a suitable permanent plan, meanwhile providing temporary homemaker service to allow enough time for the details to be worked out. A temporary solution without radical change in the family structure can protect the father from taking immediate steps out of desperation, steps which may damage the security of the family or in other ways prove unsatisfactory.

3. If the family participates in casework. In homemaker service, as contrasted to housekeeping services, the agency takes casework responsibility for the welfare of the children and hence must maintain contact with adult members of the family as well as with the homemaker. The homemaker's primary responsibility is child care rather than housework. Since she does not have professional training she relies on the caseworker for much of her understanding of the specific problems of children deprived of their mothers. To give adequate guidance the caseworker must know the details of the family situation. The caseworker also clarifies the homemaker's function with the father, and in so doing helps him to maintain his role in the family. In regular contacts with the father, she may also be able to help him understand some of his own feelings concerning his wife's illness. Casework participation may forestall the tendency of some fathers to delegate all parental functions to the homemaker, and the tendency of others to limit the homemaker to housework and menial duties.

Casework may be even more important with the mother during her convalescence as illustrated by the following abstract of a record of casework interviews with Mrs. P., a convalescent patient, concerning her relationship with Mrs. H., the homemaker:

> For the first two weeks Mrs. P. was home from the state hospital she seemed very happy with homemaker service. She then began to feel guilty that she needed a homemaker, and later complained that the homemaker's ability to handle the work and care for the children implied criticism, and seemed to emphasize her own inferiority as a mother.

> Later Mrs. P. admitted her jealousy of the place Mrs. H. had with the children. Mrs. P. also said that Mrs. H. seemed like a mother to her. She recognizes that a good deal of her reaction to Mrs. H. is a reliving of her relationship to her own mother. Mrs. P. also says that when she is feeling depressed she likes to be alone and doesn't want someone constantly in the house.
>
> From Mrs. H.'s description of Mrs. P.'s depressed days, Mrs. P. apparently withdraws from the reality around her and seems almost in a "trance", not seeing the children and not carrying out her household work. Mrs. P. frequently has asked whether having someone one or two days a week wouldn't be enough. For one week we did have Mrs. H. go in for 3 days, but Mrs. P. seemed frightened at the evidence that her idea of reduced service might be accepted. Although she feels she should manage alone she has a strong conviction that she is unable to. In my discussions around this I have tried to help Mrs. P. look at her resentment of the homemaker as acceptable and natural. I have tried to help her justify having service in order to give her more opportunity to get well. Much of this Mrs. P. can understand on an intellectual level, but she continues to struggle with it emotionally. On one occasion she mentioned "giving" the two youngest children to her sister since she could never be an adequate mother, and on another occasion she was so sure that she was bad for her family that she talked of getting herself re-committed to the state hospital to give her family a chance to escape her.

Through the agency, the state hospital follow-up clinic was kept informed of progress and problems in this patient's convalescence.

4. If the mother is in the hospital or convalescing at home, but not if she requires psychiatric nursing care or supervision. Homemakers are not trained in nursing; their primary orientation is toward child care, and they cannot undertake supervision of confused or suicidal patients. Furthermore, since the homemaker's role with a convalescent mother requires unusual tact, flexibility and understanding, an agency may not always be able to provide individuals who can adapt to the situation.

5. If the agency and the psychiatrist with responsibility for the patient's treatment maintain lines of communication. On application for homemaker service, the family is customarily asked to sign a release of medical information. Without medical information, the agency cannot properly determine the applicability of its services, and will probably withdraw from a case where medical information is not made available.

This is particularly important when the mother is convalescing at home. Often such a patient will confide in the homemaker or the caseworker. She may reveal the first evidences of relapse, or suicidal preoccupations, or dissatisfactions with treatment to the homemaker. The psychiatrist therefore should keep posted on the homemaker's observations.

> One homemaker reported: "When the 8-year-old boy was leaving for a weekend trip to his grandmother's, I heard his mother say: 'Go ahead and leave me. I'll get well while you're gone. It's you who makes me ill. You are deliberately driving me into my grave.'" The homemaker, although distressed at this incident, did not attempt to interfere with the interchange but informed the caseworker by 'phone after she left the patient's home. The caseworker used this and other similar evidence in a later discussion with the psychiatrist and the patient's husband which led to the patient's rehospitalization.

When communication is easy between psychiatrist and agency, the psychiatrist has an opportunity to suggest appropriate attitudes and measures for the homemaker to adopt. Although the milieu cannot be regulated as thoroughly as in a hospital, the caseworker passes on and interprets the psychiatrist's suggestions to the homemaker, who usually can carry them out more objectively than can either a relative or the customary type of domestic help. The psychiatrist can arrange to receive progress reports from the caseworker at regular intervals by telephone or mail.

6. If the total family plan involving homemaker service is realistic. The following case illustrates some of the factors leading to the agency's decision that homemaker service could not be provided.

> Dr. X. advised Mrs. Y., a mother of 3 small children, to enter a private psychiatric hospital. Mr. Y. was a college student who worked evenings in a bowling alley to support his family. Their income was $200 a month; Mr. and Mrs. Y. were residents of a neighboring state, and ineligible for local hospital care except in private facilities. Mr. Y.'s hospitalization insurance would cover no more than a small fraction of the hospital bills. The children needed care in the evenings when their father worked, requiring a homemaker to return home late at night with poor public transportation. (Most homemaker services can only supply day-time care.) Although Mr. Y. stated that his wife would be more upset if the home were broken up or if they returned to their home state, the agency did not believe it realistic to institute homemaker service.

EVALUATION

As with other aids to rehabilitation, it is virtually impossible to demonstrate the results of this program in clear-cut or unequivocal terms. So many factors enter into each individual situation that no adequate controls can be established, and recourse must be taken to anecdotal evidence.

Thus homemaker service appeared to alleviate the tensions in all 3 of the families mentioned in the first part of this paper. Six-year-old Cheryl, who thought she was naughty and wished she could go to heaven, became much more relaxed and began to take an interest in school and her friends. In the second case, Mrs. C.'s 12-year-old daughter, relieved by the homemaker of the responsibility of the home, could resume her little girl relationship with her father and avoid the tension associated with the role of substitute wife. The children in the third example, who had oscillated between their own and a foster home, could remain at home, even though their mother continued to have periods of exacerbation and remission. Protected by the homemaker's calm and balanced attitude, they were better able to overlook their mother's peculiarities and give her the encouragement of their support in her eventual convalescence.

Direct and indirect observations of the effects on children, on fathers, and on the patients, therefore, lead me to believe that homemaker service can make a substantial contribution which cannot be duplicated by any other existing service for any group in our society. In most agencies, therefore, homemaker care is not restricted to the indigent. Agencies with fee-for-service programs provide homemaker care to any income group, scaling the fee to the income of the patient's family. The following case is typical:

> When the mother of 3 small children required sanitarium care for a depression, the psychiatrist recommended homemaker care. The father, a well-to-do executive, could easily have hired a housekeeper through an employment agency. He recognized, however, that a homemaker was better for the children than a housekeeper who did not have the advantages of contact with casework services, or than a somewhat controlling grandmother whose presence in the house would have been a serious threat to the mother. After a few weeks the mother returned from the hospital, then relapsed, and later came home again. Meanwhile the homemaker, bulwarked by the agency, gave

consistent support both to the father and to the children through the periods of transition. She made it possible for the rest of the family to give security to each other during the mother's illness, and for the mother to return to a familiar and organized environment during her remissions.

SUMMARY

Homemaker service contributes substantially to the rehabilitation of mothers of young or adolescent children who require, may require, or have required psychiatric hospital care. It also contributes substantially to preventive psychiatry through decreasing the insecurity and anxiety of the children involved. The development of homemaker services can be materially assisted by the influence of psychiatrists in their communities.

XIII CURRENT REALITIES AND FUTURE OPPORTUNITIES FOR HOMEMAKER-HOME HEALTH AIDE SERVICES*

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I suggest that within a very few years we will not be discussing such questions as homemaker service being a "frill", who needs it, who should provide it, etc. On the contrary, we will accept the fact that this is an essential community service which must be available to all. Our experience to date already justifies this view. I know of no other specialized service which makes so great a contribution to the welfare of families, the aged and disabled, and to the services of other social agencies. It augments and extends the periphery of agency service in ways generally not recognized until experienced. It is flexible, easily adapted to the particular needs of the families served, warmly accepted and supported by clients and community.

There is a vast burgeoning of this service. We no longer see it primarily as a child welfare service but as a family service which serves all kinds of families, including the single adult living alone. We no longer limit the service to emergency or short-term services, primarily caused by illness or disability of the mother or housewife. Many agencies now provide 24-hour service where there is need for it and where it is the "treatment of choice." Long-term supportive services may continue for months or years when disability, terminal illness or other heavy family burdens require such help. We use homemaker services to raise the level of living for both young families and for older people by working with them, demonstrating and teaching them how to improve the home, cooking and nutrition, to sew and care for clothing, to take advantage of bargains to stretch the family income, to care for and train children, to provide personal care services for the frail aged, the ill and disabled--the list is endless.

One of the exciting by-products of homemaker service is the socialization which results for people, and especially for young parents and their children. The homemaker often becomes the "parent model" who transmits to these families both skills and values they did not learn in their own homes. To borrow a term from anthropology, they become the "culture bearers" for our society.

Certainly one of the basic purposes of the family is the transmission of the culture (values, knowledge, skill, wisdom, as well as customs) from one generation to another. When this basic purpose is understood and accepted by the parents--consciously or unconsciously--both they and their children tend to be happy, contributing members of the community. When it is not, problems arise.

There are so many problems and gaps in the transmittal process that many families must have help in teaching their children how to become independent, responsible, contributing adult members of society. This is especially true where mental or physical illness, disability, ignorance, poverty or lack of opportunity have seriously curtailed the capacity of parents and

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*** Paper given at National Council for Homemaker Services, Hotel Biltmore, New York, New York, May 4, 1967.**

adult members of the family to provide adequate"models" for their children. It has been said that one inherits poverty as surely as wealth. Lack of adequate parental care and rearing affects adversely the capacity to provide it to one's own children.

This leads me to the area of homemaker service which is receiving increasing attention: the use of homemaker service in families when neglect or abuse is suspected or reported. Child welfare programs have used this approach for several years now. We need greater extension of such service. As for children who were removed from their homes because of poor conditions or "neglect" or abuse--how many homes might have been salvaged and improved for them if homemaker services had been available to avoid precipitate placement? We know what problems there are for many children and their families when foster care becomes the long-term "solution." We also need to make more use of homemaker service to prevent physical and/or emotional breakdown on the part of the seriously over-taxed mother and to prevent disruption of the family because of unrelieved pressures of poverty or the work involved in the care of a large family of children, a seriously handicapped family member, the aged individual who demands a great deal of care or is difficult to live with.

I venture to suggest that if we really understood how great are the burdens of some of these housewives, parents or other family members we would be more alert to providing help before breakdown occurs. For instance, the teacher, social worker or other single woman who tries to hold down a job and care for her aged mother, father or aunt. Her own life is increasingly curtailed because she cannot leave the elderly person in the evening or for a week-end. She uses up her savings to support her parent When she can no longer carry the burden, her parent--and sometimes she herself--goes to a nursing home. Or the couple who try to rear their own brood and at the same time care for a crochety parent, who nags, complains, demands attention and generally creates tensions in the home. Eventually the parent's own relationship is seriously disturbed, children may develop problems--we all know the whole syndrome.

How different the lives of all might be if a few hours of homemaker service in the day or evening could be provided to relieve the constant, grinding strain of care for the elderly.

For some ill or disabled men it is often better to use men aides for "homemakers." This is becoming a more frequent pattern in many agencies. It should be encouraged whenever it is needed.

It is my conviction that every community in the U.S. needs homemaker service. Where it is not otherwise available to all who need it, the local public welfare agency should include it as a regular part of its own service program. Every large public welfare agency needs to have this service as a part of its own program both to insure its availability to those public welfare clients who need it and to permit coordination of this service with the other services provided to people.

It has been estimated that we would need 200,000 homemakers in the U.S. in order to provide coverage comparable to that of Great Britain. (It should be noted that Great Britain feels the need for more "home helps" than they actually have.)

We still have a long way to go in reaching such a goal. Yet, the progress made in recent years has been impressive.

A study made in 1958 found that there were 143 agencies employing 1,700 homemakers providing homemaker services to about 2,200 families during the study week. In 1963, 303 agencies administered homemaker programs in 44 states, the District of Columbia, and Puerto

Rico. These agencies employed over 4,900 homemakers, on a full or part-time basis, and provided care for about 9,600 families in the month of October.

The findings from the study of homemaker-home health aide services which was a joint project of the National Council for Homemaker Services and the Welfare Administration are now being analyzed and will be reported upon in greater detail at a later session of this conference. The study very definitely shows the accelerated growth since the 1963 Directory was issued. Briefly, some 800 agencies administered homemaker-home health aide programs in 49 states, the District of Columbia, and Puerto Rico. (Idaho is the only state reporting no organized program, although the public child welfare program has informal arrangements for services as needed.) About 8,000 homemaker and home health aides were employed on a full or part-time basis. In October, 1966, these homemakers provided service to some 24,600 families. At present, 14 states have consultants in Homemaker Services on the staffs of their public welfare departments; in 1963, only three states had them.

Communities, rural and urban, are today taking advantage of the increasing amount of Federal resources available to help develop new homemaker services. Funds to provide substantial support for homemaker service programs have been available through Welfare Administration grants to states for a number of years--through the public assistance grants administered by the Bureau of Family Services and through Children's Bureau grants. Also, Public Health Service funds have been widely used for this purpose.

Now, important additional sources of Federal aid are available as a result of the 1965 amendments to the Social Security Act. You are undoubtedly familiar with the Medicare provisions of the 1965 legislation and Dr. Cashman will be discussing the tremendous potentials of this provision as it relates to the development of home health aide services.

The second major provision of the legislation, Title XIX, or Medicaid, as it is sometimes called, is less well known. Since it is administered by the Welfare Administration--through the Bureau of Family Services, in much the same way as the public assistance grants--I will give you some highlights and relate them particularly to the development of homemaker programs.

It is important to keep in mind that, unlike Medicare which is Federally administered, Medicaid is a Federal-State partnership program. This means, first of all, that the decision as to whether or not to establish a program rests with the state. To date, 26 states, Puerto Rico and the Virgin Islands are operating Federally approved programs. We expect that 48 jurisdictions will establish programs by the end of fiscal 1968. There is a very strong incentive for states to do so because, if they do not have the program by January 1, 1970, they will be unable to receive Federal aid for medical care for public assistance recipients. The state determines what agency will administer the program (in most states it is the welfare department; in some, the health department) and draws up a plan which, if it meets basic requirements of the Federal law, entitles the state to receive Federal funds which range from 50 to 83 percent of the cost of the program. The amount is set by a formula which takes into account the varying fiscal capacities and needs of each state.

The states have considerable leeway in determining the scope and coverage of the program. To meet Federal requirements, they must provide five basic services: in-patient hospital care, out-patient care, physicians' services, laboratory and X-ray fees, and skilled nursing home care for persons over 21. The Federal law also requires that all persons receiving financial assistance under the Federal-State programs of Old Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid for Families with Dependent Children, must be covered by the Medical Assistance program.

However, the states can set up much broader programs and are encouraged to do so. For example, most of the existing programs include services in addition to the five that are specified in the Federal law. Almost without exception, these state programs provide for payment of drugs and medication, many include dental care, provide for eyeglasses and hearing aids, prosthetic devices and, in fact, most of the things a physician would consider necessary for adequate care of his patient.

Some include payment for home health aide services. Others provide homemaker services through the agency's regular social services program or secure it from other community resources.

The coverage in most states also extends beyond the groups who receive public assistance and includes other low income people who, except for having enough money to meet their normal living costs, would qualify for public assistance on the grounds of being aged, blind, disabled, or families with children deprived of a wage earner's support. About half the jurisdictions also cover any child, including those whose parents work, who needs medical care which the family cannot afford to purchase. States vary in the incomes which they consider necessary for normal living expenses. The most generous level is that of New York where a family of four with one wage earner can have an income of $6,000 a year and still be eligible for Medicaid coverage after making a small payment known as a deductible. In most other states, the cut-off point is between $3,600 and $4,200 for a family of four.

This is of course a medically oriented program. It cannot contribute to the cost of homemaker service given to deprived families primarily to help them raise their living levels. It can pay for home health aid provided to people who need help because of illness or disability. To the extent that services can be financed with Medicaid funds, other public funds are freed to pay for service to deprived families that do not have pressing medical problems. Thus, the total homemaker service program can be expanded. If this is to happen, however, two things are important: first, that the state's Medicaid plan include provision for home health services for this particular emphasis and that such services actually be available. Second, the best way to assure the establishment of homemaker services as a regular part of the statewide public welfare program is to have a specialist or specialists on the state staff. Federal funds can normally pay approximately 75 percent of the total cost of such programs.

From a practical standpoint, this avenue probably offers our best hope for rapid expansion of homemaker services to the groups that need it most. Therefore, I hope each of you will find out what is happening in your state and work with your fellow citizens to assure that effective use is made of this great potential resource for homemaker service.

Not that we should rest content to have the service available only to low income groups nor should we consider the public welfare agency the only type of organization where rapid expansion is feasible. There has been an impressive growth of homemaker programs under public health auspices and under voluntary health and welfare auspices. We need all of these efforts and more of them for, as I indicated earlier, under the conditions of modern living, homemaker service at some point of time becomes a real necessity for just about everyone. The more widely it is known, the greater the demand is bound to be.

Fortunately, this is a field in which it should be relatively easy to expand personnel to meet rising demand.

Homemaker service is a vocation which offers employment to a readily available pool of women and much of the effectiveness of any program depends on the women who give this service. There are many women with the needed qualifications in our communities--some may be assistance and former assistance recipients; some may be beneficiaries of Social Security or other retirement plans who wish to supplement their income; or they may be women with older children who wish to work part-time. Also, as I mentioned before, men make excellent "homemakers" or "health aides" in certain situations. The potential sources of recruitment have barely been tapped.

Along with a favorable picture in terms of potential manpower and increased financial resources, I think we can also look forward to improvements in delivery of services, which will make it easier to operate all types of service programs including homemaker services. What I have in mind is the growing interest in developing multi-purpose neighborhood service centers in the heart of every low income neighborhood. Five Federal agencies are now pooling resources to get such centers started on a demonstration basis in 14 major cities and, in addition, literally hundreds of communities are beginning to develop some variation of the service center program. For the pilot demonstrations, the Department of Housing and Urban Development will construct or renovate a facility so that it will be specifically designed for a center. The Departments of Health, Education, and Welfare, and Labor, and the Office of Economic Opportunity will help to support services and the Bureau of the Budget will help to coordinate financing.

The Federal agencies will be working closely with the states and the cities in developing the models. The goal is to make it possible for troubled people in low income areas to get a broad range of services without having to go to many different places and to receive services on a piece-meal basis.

Ideally, financial assistance, social services, legal aid, employment counselling and placement, health clinics, and, most certainly, homemaker services, would be available, and whatever combination of services an individual or family needed would be provided in a coordinated way. The center could house both voluntary and public services, with a center manager to assure that the providers of the services did not merely co-exist but did, in fact, coordinate their services.

The development of such centers will not only increase the demand for homemaker programs but will also facilitate their administration and operation.

In brief, all the signs are "go" as far as the growth of homemaker programs is concerned. Let me then, in closing, suggest a few basic principles to keep in mind as we move ahead:

1. Broad scale programs which serve families with children, aged, ill and disabled adults in the community. Increasingly, communities are looking to welfare and health agencies to provide a full range of services to all who need them, not just a selected few according to very restrictive policies which these agencies set up.

2. Responsible administration which assures a quality service in appropriate amounts, as needed. This means that the agency must be responsible for the quality of the persons selected to be homemakers and provide suitable training and direction of them. They must be as much a part of the agency as caseworkers, nurses, secretaries or other staff, responsible to the agency, which in turn must be accountable for those workers, as for other staff.

Responsible administration means that the agency, through appropriate staff, must review and evaluate requests for service, determine if this or some other service is needed, and what other services must be provided along with homemaker services. It does not mean that homemakers can operate on their own, making their own decisions as to whom they will serve, how much, what they will do, etc. It also means a pay scale for homemakers and aides commensurate with the tasks they are to perform, as well as other employee benefits.

It means that other agency staff will be a part of planning and carrying out this service, and that the total plan of service--social, health, financial and other--will be coordinated to meet the specific needs of each family.

3. Accountability to the community for quality and quantity and cost of service provided--community means local, state and national, and it means clients are citizens and are a part of the total community of available services and of the unmet needs. It means involving the community in developing needed resources and extending services, in casefinding and assuring that the service is readily accessible to all who need it.

As of this point in time we cannot honestly claim that we have achieved programs which uniformly reflect all of these principles. We still have many problems to be resolved agency by agency. Our goals should certainly include them.

However, we are at long last on the move; homemaker service is growing by leaps and bounds. Is it too much to hope for a broad program of services throughout the land in the next ten years? If we try, I believe we can have the kinds of programs I have talked about and have them in sufficient quantity so that everyone who can benefit from homemaker service will find it readily available.

Illustrative Materials

ACKNOWLEDGMENTS

Case capsules, case vignettes, and some records and reports written by homemaker-home health aides are included in this Unit of Learning. These were selected from materials submitted by executive directors, training supervisors, caseworkers, visiting nurses, supervisors of programs, and homemaker-home health aides on the staffs of operating agencies.

Several of these pieces of material are grouped under suggested teaching guides. Others are included as additional examples which reflect the scope and range of the service and its flexibility.

For assistance in preparing these illustrations the National Council for Homemaker Services wishes to acknowledge with gratitude the following agencies which submitted materials:

Association for Homemaker Service, Inc.
New York, N.Y.

Berks County Home Services
Reading, Pennsylvania

Calgary Family Service Bureau
Calgary, Alberta

Canadian Welfare Council
Ottawa, Ontario

Child and Family Services
Chicago, Illinois

Children's Aid Society
New York, N.Y.

Cleveland Homemaker Service Assn.
Cleveland, Ohio

Community Homemaker Service of
Jewish Family Service
New York, N.Y.

Connecticut State Welfare Department
Hartford, Connecticut

Division of Homemaker Service
New York City Department of Social Services

Homemaker Service of the National
Capital Area
Washington, District of Columbia

Homemaker Service of Metropolitan
Detroit
Detroit, Michigan

Homemaker Service of San Diego
San Diego, California

Jewish Family and Community Service
Chicago, Illinois

Minnesota State Department of
Public Welfare
St. Paul, Minnesota

North Carolina State Department of
Public Welfare
Raleigh, North Carolina

Public Welfare Board of North Dakota
Bismarck, North Dakota

San Francisco Home Health Service
San Francisco, California

Self-Help of Emigres from Central Europe
New York, N.Y.

The Family Bureau of Greater Winnipeg
Winnipeg, Manitoba

Visiting Nurse Association
Detroit, Michigan

Visiting Nurse Service of Rochester
and Monroe County
Rochester, New York

THE USE OF CASE VIGNETTES, CASE CAPSULES, AUDIOVISUAL MATERIALS AND ACTION MEDIA IN TEACHING

> "Learning takes place through the active behavior of the student; it is what he does that he learns, not what the teacher does."[1]

> "The old idea that learning can be fun was not wrong; it was only misinterpreted by many that learning should be easy in order to be fun."[2]

The so-called audiovisual media for teaching are sometimes classified under the headings of projected media (such as filmstrips,slides, and other transparencies), non-projected media (such as books, charts, graphs, pictures, diagrams, and models), and auditory media (such as tape or radio recordings and discs). A fourth category may be added -- action media -- among which would be included such diverse activities as field trips, putting on a "rumor clinic", dramatic presentations, and role playing.

A field trip, when carefully planned in the light of a specific teaching objective, is for many students a dynamic learning experience. When adequate preparation is made beforehand, when observation is purposefully directed during the course of the visit, and with well-coordinated discussion afterwards, the field visit can elicit an active learning response from those who participate in it.

Seeing for one's self through a field trip and by means of taking part in or observing a "rumor clinic", may reveal to the student to what extent people tend to read into what they actually see that which they expect to see, and how pre-conceptions distort what takes place before one's very eyes. This can stimulate and reinforce the self-awareness so necessary for working with people of whatever age. It can also serve as a springboard for discussing pre-judgments and the importance as well as the difficulty of accurate observation.

Dramatic presentations are helpful in highlighting ideas and in focusing attention on feelings. A drama can provide a discussion group or class of students with a meaningful point of departure for thoughtful consideration of feelings and attitudes given certain circumstances and life situations. Awareness of how it feels and how one might behave from the viewpoint of providing or being on the receiving end of a health or social welfare service may be perceived. Reading one of the "Plays for Living" in the classroom, for example, with or without prior rehearsal, may heighten the interest of the group in discussing the feelings of the characters in the play and problems they are experiencing.[3] The character portrayals may be more sharply drawn than the description of individual clients or patients in a teaching case record.

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[1] Ralph W. Tyler, Basic Principles of Curriculum and Instruction. Chicago: University of Chicago Press, 1950, p. 41.

[2] Report of the Cooperative Project on Public Welfare Staff Training, Volume 1, Washington, D. C.: U.S. Department of Health, Education, and Welfare, 1963, p. 105. Dr. John W. Gardner, then President, Carnegie Foundation, was quoted from a newspaper interview in 1963.

[3] Catalogue available, Plays for Living, Family Services Association of America, 44 East 23rd Street, New York, N. Y. 10010.

Role playing is another action medium which appears increasingly to be finding favor among many teachers. Broadly defined it is the "spontaneous acting out of roles in the context of human relations situations."[4] As such, it is distinguished from psychodrama which is primarily therapeutic in intent and is concerned with "a unique problem of a particular individual". Experience seems to show that the more clearly yet simply the situation is set and the roles specified, and the more spontaneous the action, the more successful the role playing is likely to be as a teaching medium.

Role playing should not be used in teaching as a "gimmick" or attention getter, or simply in the effort to "liven up a group". Like the field visit which may be incorrectly used without adequate planning and purposeful direction, the role playing, too, could fail in becoming a vital learning experience. Used planfully and at the right point in sequence in the development of learning experiences it may have many advantages. It can bring a situation or human relations problem into sharp focus for a group, often in a way which enables them to see the many ramifications in relationships, to identify connecting links, to analyze what is taking place, and to consider alternative lines of action. It enables the group to "live through" a situation by acting it out or observing some of the group members act it out. It can serve in a sense as a kind of "rehearsal for reality" by providing a situation in which newly learned ways of behavior can be tried out and tested, without the risks that would be involved in real life situations.

In setting up the role play, the problem or situation to be acted out should be defined by the teacher, by the group, or frequently by both together. It goes without saying that it should be firmly set in the context of what is being taught as a whole. It should be briefly and simply suggested and not spelled out in detail. Once the participating members are clear about the situation and role they are to play they are free to develop the words and feelings as they imagine such characters to behave and feel. A time limit of five to fifteen minutes should be defined.

The case vignettes and case capsules may suggest situations for role playing. Also, without role playing, they will provide the teacher and students with situations for discussion. In contrast to the more complete teaching case records and clinic reports used traditionally in professional schools, these abbreviated accounts permit the teacher and the students to project their imaginations into the highlighted situations. Discussion of actual techniques and steps in treatment, with the resulting value judgments or the pragmatic approach as to what was correct or incorrect procedure, may more frequently occur in the use of chronological recording. Thus the time-honored "process recording" may appear to bind the teacher and class to the didactic method of teaching. Students and teachers may get caught into wanting more specifics and in being critical of the techniques used.

The case capsule, which poses a problem or summarizes a situation without details as to cause and effect, can be used flexibly by a teacher who is clear about the point to be made in the use of a selected incident. Used as a writing assignment with questions for directing the student's thought to a principle, to alternative assumptions, or to possible solutions, the case capsule of 100 words or less is particularly efficient. A discussion of possible ways of doing, of certain techniques which might be used, without the detail of what steps had actually been taken, may stimulate more problem-solving thought and may free the students and teacher to project their own ideas more creatively.

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[4] Grace Levit and Helen H. Jennings, "Learning Through Role Playing," in W. G. Bennis, K. D. Benne and R. Chin, The Planning of Change: Readings in the Applied Behavorial Sciences. New York: Hold, Rinehart and Winston, 1962, pp. 706-710.

The case vignette must be capable of engaging an immediate identification with a feeling and often with a situation. It, too, can pose a problem, but its value in teaching is that of its pliability, as well as its focus. Teachers testify they can "hold to the point" with a vignette carefully selected for illustrating a feeling or the uniqueness of a situation which provides a teaching point about a principle to be learned. The case vignette does not show the element of time and change as the case capsule may do. Its instantaneous effect is the response which it elicits from the group. Learners remember their feelings about a situation more than they retain the facts. Consequently the kind of feeling tones which well chosen vignettes can evoke, used purposefully by a teacher who knows why he is using this kind of material, will have positive learning values; and the point which is being taught may be said to be learned and not just remembered.

It is the expectation, the charge, on the part of society that members of the helping professions will know how to help others deal with their feelings -- patient, client, employee, even neighbor, friend and relative. In teaching materials for courses in professional schools dealing with feeling behaviors it is especially important that the kinds of materials chosen will provide the stimulus to engagement on the part of the teacher and the learner for genuine thought-provoking, problem-solving, theory-made-applicable to real life situations. The case vignette, a poem, a letter, a cartoon, a few sentences from a novel or a newspaper report can provide useful learning experiences.

Audiovisual materials are more readily available these days among the many sources of state departments of health, welfare, or education film libraries and the tape repositories.[5] Films, film strips, videotapes, radio recordings, and audio tapes can be valuable educational tools if used with imagination and selectivity. The impact that a film, or a voice may have will heighten the feeling of participation on the part of the learner. Involvement of the student more actively in the learning process is increased when more of his senses are used -- hearing, seeing, feeling, smelling, even tasting. Teachers who use such educational tools find that the realism of instruction is increased, the imagination is stimulated and that students are frequently motivated to undertake more independent study outside of the classroom experience when they have been awakened to a more active engagement in their own learning. Like any tool the uses to which they are put and the results which they achieve depend upon those who work with them, the care with which they are selected for a specific educational goal, and the variety and quality of the audiovisual aids.[6]

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[5] Tape Library, Audio-Visual Center of Kent State University, Kent, Ohio, and National Tape Repository, Bureau of Audio-Visual Instruction, Stadium Building, Room 346, University of Colorado, Boulder, Colorado.

[6] Dale, Edgar. Audio Visual Mehtods in Teaching. Rev. ed. New York: The Dryden Press, 1954.

AUDIOVISUAL AIDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES

DRAMA

TO TEMPER THE WIND -- A 30-minute drama requiring a cast of five and a stage manager; no scenery, a table and four chairs. Designed to show community groups how homemaker-home health aide service steps in at a time of crisis, prevents family breakdown, and brings out the inherent strengths of the family. Written by Elizabeth Blake and produced in 1964 by Plays for Living, a division of Family Service Association of America, for the National Council for Homemaker Services. Available from the Council, 1740 Broadway, New York, N.Y. 10019. Single copies of script, $2.; production kit of six, $12.

FILMS

Films which have been produced by the MENTAL HEALTH FILM BOARD, 8 East 93rd Street, New York, N.Y. 10028, are available for sale from the Board and from its contracted distributors, the International Film Bureau, Inc., 332 S. Michigan Avenue, Chicago, Illinois 60604. Rental of these films is handled by the New York University Film Library, 26 Washington Place, New York, N.Y. 10003. Free distribution of all Mental Health Board films is usually made within a state's own boundaries by the state department of public welfare or the state department of mental health. Schedules for the free loan are booked far in advance. Distribution of other films is with the producer or sponsor as listed.

BOLD NEW APPROACH -- A 62-minute black and white sound film, 16mm. Presents the concept of the Comprehensive Community Mental Health Center, stressing continuity of care; photographed in ten locations in the U.S. and one in Europe; shows multiple services that should be available for troubled people of all ages within their own communities; explains the relationships of the various professions to each other. Produced in 1966 by the Mental Health Film Board, sponsored by the National Institute of Mental Health. Rental, $15.00 per day; purchase, $195.00.

HOME AGAIN -- A 30-minute black and white sound film, 16mm. Shows a homemaker in the home when the mother returns from hospitalization with a serious heart condition; emphasizes the careful supervision of the homemaker by professional staff members of the agency, the training and preparation of the homemaker before assignment. Co-sponsored by the Alaska State Department of Health and Welfare, the New Jersey State Department of Health, and the American Heart Association, the film was produced in 1958 by the Mental Health Film Board. Rental, $8.50 per day; purchase, $145.00.

HOMEFIRES -- A 28-minute black and white sound film, 16mm. The story of homemaker-home health aide service is told dramatically through one homemaker-home health aide who is shown at work with three different families facing a variety of problems: a family with a mentally ill member, an aged couple, and a family in which the mother is being rehabilitated after an accident. Produced in 1967 by the Mental Health Film Board, with funds provided by the Office of Education, U.S. Department of Health, Education, and Welfare, particularly for use in training homemakers but generally for interpretation of the service as well. Rental fees are $8.50 per day, $25.50 per week, and $68 per month; purchase price is $150.

THE HOME HEALTH AIDE -- A 20-minute sound film in color, 16mm. Selection, training and responsibilities of the aide, as the newest member of the health team, are presented in detail. Aide trainees make observation visits with a public health nurse to watch experienced aides performing their duties. Designed as a training tool for the home health aide, the physician and allied professional groups, the film may also be used to interpret the service to community groups. Produced in 1967 for the Colorado State Department of Health and possibly available from other state departments of health; otherwise available only for purchase from Barbre Productions, Inc., 2130 S. Bellaire Street, Denver, Colorado 80222 at $190.

THE RIGHTS OF AGE -- A 28-minute black and white sound film, 16 mm. This film dramatizes the story of one recluse who, like many old people, attempts to be self-sufficient long after she is able to manage effectively. Not until she becomes physically disabled does the community have a chance to extend to her the various benefits now available for the aged. The film features 20 to 30 other old people, all in need of physical, psychological or legal assistance. Produced in 1967 by the Mental Health Film Board, and sponsored by the Pennsylvania Department of Public Welfare, Office for the Aging, this film won the Chris Statuette Award at the Columbus Film Festival as the best social documentary of the year. Rental, $8.50 per day; sale, $150.00.

WHEN THE BOUGH BREAKS -- A 14-minute sound film in color, 16 mm. A dramatization of homemaker services in a family situation involving the illness of the mother, emphasizing prevention of placement for the children. Produced in 1960 and available from the Family Service Association of Nassau County, 286 Old Country Road, Mineola, New York 11501. Rental, $5.00 per showing; purchase, $125.00.

FILM STRIPS

ANYBODY'S CRISIS -- A 25-minute black and white sound film strip. Also available mounted on tape which can be shown on 35 mm. projector, with synchronized narration. Produced in 1960 by the National Committee on Homemaker Services, it is now available through the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019. No rental fees but handling charges of $2.00.

ENTER HOPE -- A 15-minute film strip in color, for 16 mm. or 35 mm. film strip projector and record player for a 16 inch 33 1/3 recording. Shows the training of homemakers, the kinds of services they give, and the benefits accruing to the patient, the aged, and family groups, a "true story of Community Homemaker Services in New Jersey." Write State Consultant, Community Homemaker Service, Division of Chronic Diseases Control, State Department of Health, Trenton, New Jersey 08625.

WHAT IS HOMEMAKER SERVICE? A 10-minute black and white sound, for 35 mm. slide projector, synchronized narration, any tape recorder with 3¾ rps speed. Shows homemaker assigned to work with a family of three children whose mother has been hospitalized; relationship of the homemaker to family members and agency staff; training and duties discussed. The narrator points out the value of the service to the chronically ill and aging, mentally ill and physically handicapped as well as to the families with children. Produced in 1965 by Child and Family Services of Chicago and contributed to the National Council for Homemaker Services. Script accompanies the film strip. Available from the Council, 1740 Broadway, New York, N. Y. 10018; rental $5.00 for two weeks; purchase $100 per set.

SELECTED CASE ILLUSTRATIONS

HOMEMAKER'S REPORT

SUMMARY:

In a number of agencies homemaker-home health aides are required to file written reports at specified times. These illustrations indicate something of the meaning of their job experiences to the aides and the way in which they view their responsibilities and the clients whom they serve.

INDICATED USE:

For classroom discussion to illustrate varied assignments of the homemaker-home health aide staff members; to help students and agency staff members gain an understanding of the quality and the nature of the aides' jobs. These materials could also be used for administrative purposes in developing a format for recording by the homemakers and for developing evaluation procedures on the aide's job performance, or for evaluating the service itself.

SUGGESTED METHOD OF PRESENTATION:

Several illustrations might be distributed in advance as assigned reading for classroom discussion or for a staff meeting on the subjects suggested by the materials. Discussion might include:

- consideration of the values and purpose of requiring written reports from the homemaker staff members.
- the pros and cons of supervision without recorded case material.
- awareness of the meaning of the homemaker-home health aide job of serving clients through homemaking skills and in a relationship with professional members of the staff.
- consideration of the motivations of staff members performing this function.
- recognition of the personal involvement in the family life of clients which the aides experience which is different from that experienced by other staff members working with the same clients.

(Typical homemaker reports on following pages)

A HOMEMAKER'S REPORT

"The first case is the family I have been working with over two months on one-half day, three times a week basis. The 21-year-old mother has just had her fifth child. The father is twenty-six years old. He is sometimes employed mowing lawns and doing other odd jobs. My job was to teach the mother how to cook and to care for her children, to help her plan her menus and do marketing on approximately $20.00 a week plus commodities, and to give what supervision I could to the 17-year-old retarded girl, a cousin, who was in the home to help the mother. To date the mother has learned to bake bread, make meat loaf and three or four casserole dishes with ease, but has difficulty remembering to fix milk for the children. I have been trying to teach, by example, such things as how to get along with children, how to tackle such problems as a basement filled with filth, and how to do minor repairs in the home.

Then there is the work I have been doing in helping public assistance clients to use commodities. I have been working closely with the home economist in the Agriculture Extension Service. There are 1,500 families eligible for commodities in our county. I have prepared hand-out materials on 'How to Use Dry Milk' and suggestions for 'Using Canned Beef'. The recipes have been taken from the Agriculture Department materials, from clients, from personal experimentation and other sources. On one occasion, when I wished to experiment with the canned beef, I invited two clients down to the office to help prepare the dish and then we had several caseworkers in for lunch. This seemed to work out so well that the home economist and I are planning more activities for the fall.

One afternoon every week I have a sewing class. This activity is related to others we are planning for the future. We want to have a number of small interest groups and provide nursery care for members' pre-school children -- hopefully by volunteers. We use a room with good light, nice table space and a small kitchen which is available for our use in the Court House. We have a sewing machine made available by the Singer Sewing Company. The mothers do more talking about their individual problems than sewing. They are enthusiastic about the showing of movies on child development during a sewing session. The city nurse helped with the discussion.

Another example is my work with a family having a great number of problems. I have been concentrating on the mother who is on a provisional discharge from a state mental hospital and her midget daughter who will be starting school this fall. I have been trying a 'Head Start' type of program with both of them. We went to call on the child's teacher and had coffee. I take them flowers, magazines and papers, and made a scrapbook with the little girl."

* * *

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HOMEMAKER REPORTS

B FAMILY:

Type of family: 6 children. Mother with severe health problems, ulcerated legs and hemophilia. Father, day laborer.

Purpose of going into home: To assist mother with household tasks and insist that she gets bed rest and medical attention.

What has actually been done: I was in this home every day for four weeks while the mother was in the hospital. After her return to the home I have been going once or twice a week to do the family washing and help her with other housework.

Improvements: This mother will continue to need help indefinitely. She is pregnant again and unless she stays off her feet she may lose this baby as she did the last one.

Time spent in home: 176 hours over a period of seven months.

* * *

L FAMILY:

Type of family: Widow, 81 years old.

Purpose of going into home: She was unable to take care of household tasks because of physical weakness and we wanted to keep her in her own home as long as possible.

What has actually been done: I have been assisting her in the household tasks including laundry and shopping. I see to it she gets to the doctor for her appointments.

Improvements: She will continue to need help, although she is quite well for her age.

Time spent in home: 88 hours over a period of four months.

* * *

W FAMILY:

Type of family: Father, mother, 4 children.

Purpose of going into home: Mother needed training in all phases of homemaking. The family is all somewhat retarded.

What has actually been done: I helped her wash, and get the place cleaned up, then helped them move to a better house. I now make regular weekly visits helping her in all phases of homemaking and child care and especially in shopping.

Improvements: She is much more interested in keeping her home neat and seems less nervous and depressed. The children are cleaner and probably get better food.

Time spent in home: 130 hours over a period of six months.

* * *

Homemaker service: Horton, Marcella, age 31
6 children -- ages 10, 9, 8, 5, 4, 2

Reason service requested:

Mrs. Horton returned from the state hospital but is unable to function in her home without help. She cannot face up to the needs of her family. She is still depressed. Conditions in the home are deplorable. There are problems of money management. She is neglectful of her children and has been accused of being abusive to them. Being threatened with the possible removal of her children, she is uncertain about homemaker services, thinks children will be removed by the homemaker.

Goals: To prevent mother from returning to the state hospital
To keep the family together
To teach housekeeping procedures
To teach money management
To teach meal planning and preparation
To strengthen parent-child relationships
To get children to school regularly

Assignment: Service has varied from three and four half-days per week down to one half-day, depending on the situation.

Goals accomplished:

Homemaker was able to sell herself to this very depressed and fearful mother, even though Mrs. Horton disappeared the first day of homemaker's assignment.

The home was very shabby with living room and bedroom furniture propped up on tin cans. There was practically no kitchen equipment and few dishes. Now there is some nice furniture throughout the house and curtains at some of the windows. Some of this was acquired because of the budgeting arranged with Mrs. Horton and some by donations.

Children attend school more frequently, usually have breakfast before they go, and are dressed better than before. The children seem to fight less with each other.

One of the children, with serious allergy problems and an eye problem, is taken to the clinic regularly for treatment. Another child with serious behavior problems is now being seen at the child guidance clinic. The homemaker was helpful in encouraging and escorting the mother and these children at first to the clinics.

Mrs. Horton, who would hardly speak to any strangers two years ago, is now helping the dentist in the public school. She reports regularly to her psychiatrist. Diet of the family has improved and the welfare check seems adequate to meet the necessities of life.

While Mrs. Horton shows a real concern for her children and warmth and affection to them, she lacks understanding about how to train them. Because of serious problems of the oldest child there is a plan to remove this child from the home.

* * *

HOMEMAKER'S ENTRY IN THE CASE RECORD:

Family Group: Mrs. S. and five children, ages 17 to 2 years.
Type of assistance: AFDC
I went to the S's home with the caseworker. He introduced me to the client. We found everything in an unsanitary condition; a large wash tub overflowing with garbage, only a foot path to the out-door toilet because weeds and grass had grown so tall. The children were unfed and their clothing very ragged and dirty. Their hair was gluey and uncombed.

Mrs. S. was a very nervous person. Her son had been taken away by the Domestic Relations Court because of neglect. The Court also threatened to take all the children from this mother because neither did she keep them in school nor take good care of them. The following week I carried the mother and the other four children to the Domestic Relations Court at the request of the court. After hearing the report of the caseworker and the homemaker about the improvements that had been made since a homemaker was in the home the judge let Mrs. S. take her children back home and recommended that the homemaker continue to help in the home at least twice a week.

We have been back in the Court twice again to report. The judge saw such an improvement that the family and the department of public welfare were complimented. Betty, the 12-year-old daughter, had been complimented by her teacher for her attendance and how she has improved in her studies and appearance.

Mrs. S. is very happy, so much so she thanked the homemaker and the caseworker for coming to her assistance.

The homemaker carries this as an active case, but instead of going two days each week to the home I now visit once or twice a month. This is to help Mrs. S. with budgeting and other home problems as well as to keep the client moving forward instead of backward. I have been visiting in this home for nearly three years now.

CASEWORKER'S ENTRY IN THE CASE RECORD:

There has been a tremendous improvement in this home, due to the excellent services rendered by the homemaker. Mrs. S's outlook on life is markedly changed; there has been an improvement in her relationships with relatives who live nearby and who now return friendly visits and help the family in many ways. The school reports for all the children are much improved. Psychological testing reveals Mrs. S's mental ability is limited. Homemaker services will be needed in this home for a long period of time to prevent deterioration, and to provide emotional and physical supports in daily problems of living,

* * *

The K Family (Case record entry by a homemaker)

Source of referral: Interested neighbor, school, and Department of Veterans Affairs

Family members: Mr. K, 36 years, three months in Veterans Hospital. Mrs. K, 28 years, cannot read or write, little knowledge of homemaking. Children, ages 8, 7, 6, 5, and 1, seem poorly fed and clothed, and frequently sent home from school because of foul odors.

Housing: Four room house in run-down condition, pump outside, doors and windows broken. Two beds for the family of seven. Only one burner operating on the stove. Large quantities of donated foods stacked on the stairway, some spoiled home-canned food. Boxes of clothing stacked in every room, most of it donated by people who failed to realize the old formals and fur coats were not practical for this family.

Service required and given: In this situation the housing was of such poor quality that no improvement could be made without a change. A modern house was found and the owner cooperated in painting, repairing and building in closets. Two homemakers helped mother sort and dispose of the clothing, keeping what could be renovated for the children. Household equipment was inventoried, lists made of minimum requirements. Three days with two homemakers and the mother working were required to sort out and dispose of the spoiled canned goods and other debris. Special allowances were obtained for bedding and basic articles of clothing and some household furnishings. Veterans Affairs, the community warehouse and the Department of Public Welfare supplied needed items. When the new home was ready the homemakers assisted the mother in getting settled. It was not until this was done that teaching and training the mother in basic household routines could be attempted.

Goals Attained:

1. Mother has been able to maintain a reasonably well-kept house, following a daily pattern of household tasks outlined by the homemaker.

2. Although mother could not read or write she was taught to bake and cook by use of pictures and demonstration.

3. The mother has also been taught good hygiene practices in bathing the children, use of toothbrushes and care of skin and hair.

4. Children have responded to the new environment surprisingly well and mother has appeared to accept and follow advice on child discipline at times.

5. Food and nutrition has improved. Special help was given in planning well-balanced meals and making full use of donated foods.

Current status: Family appears to be functioning in a more acceptable manner. The chaotic disorder is no longer present, parents are cooperating in the changed pattern of living thus avoiding the serious neglect charges.

Future goals: To maintain the present gains in (1) Homemaking, (2) Nutrition, (3) Child Discipline, (4) Personal Hygiene, (5) Money Management.

* * *

A HOMEMAKER WRITES --

"After reading the article of 'How Death Affects a Child' I wonder which would leave the child more disturbed and insecure, the death of a parent or the separation of children from divorced parents where the mother has been placed in a mental hospital. Death is final, but what of the prolonged agony of the child of the mentally ill mother.

On one of my assignments, during the night this mother was rushed to the hospital because of a severe mental disturbance and later placed in another hospital for longer term care. Officers brought the frightened children to the Hillcrest Home that first night and the following day I accompanied Miss Riley, the social worker, to the Home. The children were released in my care until other arrangements could be made for them to be cared for by relatives.

The children seemed to be very well behaved and most happy to be back in their own surroundings, but they sorely missed their mother and told me they wanted to be with their father who was employed in another state. The little four year old watched every move I made. 'This is mommy's,' he would say, 'You mustn't touch this.' Every morning he needed to make sure that I didn't have his mommy's shoes on -- which were the same color. He also had to be reassured that the food he was eating had been purchased by his mommy and that she wanted him to eat it. The seven-year-old boy was much too quiet, spending hours with his tinker toys and blocks.

The ten-year-old boy was restless and deeply affected by the strange actions of his mother. He did very well in the daytime to hide his grief but at night he would sob, even in his sleep. One night when I went to him he burst into deeper sobs and then almost convulsive trembling. After he had calmed down he said, 'I can't seem to help but cry, I guess I'm not very grown up, am I?' I told him that grown men and women cry too, and that sometimes crying was just about the best medicine on the market, and also if he had any problems he would like to talk about I would be there to listen and answer his questions to the best of my ability, and that if we needed more help Miss Riley, the social worker, was coming the next day and he and I could both talk to her. His first question was 'Why is mother in the hospital and will she get better? She screamed during the night and was terribly frightened by that blackkiller cat when they took her away, but I don't believe that was all that made her sick. She says she is the sunshine and Grandma is the rain'. I reassured him that his mother was getting the best of care and for the time being the hospital was the best place for her, that sometimes mothers get awfully tired to the point where they worry over everything and become ill and need special attention and rest. What they say and do at that time doesn't always make good sense, just like tired little boys saying and doing things they wouldn't otherwise do if they were rested and felt all right. He showed me the black cat that had so frightened the family. The children all feared the cat. I picked the cat up and patted it and they gingerly stroked it. The cat purred and this eased their fears.

When the father came the three boys seemed deliriously happy and begged to go back with him. Then the uncle and his wife came, and both happy and tense hours followed. The uncle and aunt were given custody of the children and returned from the court escorted by a policeman. As Miss Riley advised me I told the children their mother would be moved to a hospital near them and they could visit her. Their father also plans to visit the children soon, but the boys seemed very shy with the uncle and aunt as they all left in the car."

* * *

ADMINISTRATIVE PROBLEMS
IN
HOMEMAKER-HOME HEALTH AIDE SERVICE

SUMMARY:

The brief, descriptive incidents in this group of materials illustrate some of the kinds of problems with which administrative staff members must deal in the operation of a homemaker-home health aide service. They include untrue accusations against an aide by a sick and possibly senile client who demands the aide's dismissal and replacement, the matter of overtime pay for work not assigned by the aide's supervisor, the problem of fee charging and collecting, and the "unreasonable" behavior of sick people. All require administrative decisions based on sound administrative policy and social work principles.

INDICATED USE:

For class discussion regarding the development of administrative policy; for illustrating the variety of administrative and supervisory problems which can arise in the operation of a tangible service of this kind; and for introducing students to reality factors in the service which require foresight and careful administrative planning.

SUGGESTED METHOD OF PRESENTATION:

Two or all of these illustrations might be distributed in the classroom for reading together, or presented through an overhead projector during discussion of each "problem". Also, one or more of these examples could be assigned in advance for individual student presentation, for leading the discussion in class, or for a written assignment.

Discussion should include:

...the concept of team relationships among the social worker, nurse and the aide which implies mutual sharing and respect for individual skills and judgment.

...the concept of supervision as a shared responsibility, and freedom to use individual judgment without fear of being penalized.

...emphasis on the purpose of the service as a commitment which all members of the staff share.

...recognition of the flexible attitudes and approach essential to the application of consistent agency policies, based on social work principles.

...the development of agency policy from experiences arising out of practice at all staff levels and with the variety of case situations for which the agency is prepared to serve.

(Case illustrations on following pages)

Mrs. Klein, homemaker-home health aide, had been a nurse in her native country, and had had ten years experience with the agency providing homemaker-home health aide services. She knew she was not to work beyond the agreed-upon hours without prior permission, since extra and overtime pay could not be assured.

When the patient's condition worsened, in the home where Mrs. Klein was assigned, on a late Friday afternoon she found she could not reach her supervisor at the office. She followed the doctor's suggestion that she return to the family Saturday and Sunday, although the patient was admitted to the hospital that evening. The patient died within the week.

When explaining to the supervisor why she worked those extra days Mrs. Klein said, "I had to; they needed me. They were so frightened. I could not consider that I might not get paid."

* * *

Mrs. Emmons, 28 years old, was hospitalized for a postpartum depression shortly after her second child was born. She left behind a dirty home, a frightened seven year old, the three-week-old baby, and a depressed husband. A homemaker about the same age as Mrs. Emmons was placed in the home. This was one of her first assignments and she was eager to make a good impression. She performed many extra chores as well as restoring order, cleanliness, and regularity in the household. Soon glowing reports came to Mrs. Emmons from her husband of the homemaker's skill and many achievements. Mrs. Emmons' depression increased and she showed much apprehension.

Through counseling with her supervisor the homemaker came to understand the effects of her actions on the absent mother. She telephoned Mrs. Emmons at the hospital to ask for her advice instead of waiting for Mrs. Emmons to telephone the home. The homemaker sent notes and pictures of the children to the mother. When the mother came home six weeks later the two women were able to work well together, with homemaker's services gradually diminished to two half-days each week until termination some months later.

* * *

Mrs. James, 82 years old, accused the homemaker of stealing. The caseworker learned that the homemaker had re-arranged the pots and pans, putting the long-handled pans away; but Mrs. James had forgotten this. She suffered from organic brain syndrome, her hands trembled and her coordination was very poor. Consequently it was unsafe for her to use certain articles around the stove. The caseworker and homemaker attempted to reassure Mrs. James about this, but Mrs. James demanded the homemaker's dismissal, even though the out of sight cooking utensils were brought out of hiding and the safety measure explained.

* * *

Mr. Rossi told the homemaker, Mrs. Jacobs, that he is spending less money on food and the family is eating better than they ever did when the mother was in the home and doing the marketing and cooking. He constantly complains about his wife's poor management and housekeeping abilities and commented recently that he hoped the doctors would keep Mrs. Rossi hospitalized for another month at least. He thought he could get caught up on the bills. Then he expressed the wish that Mrs. Jacobs would stay on and teach his wife something about how to manage the house. Mrs. Jacobs feels somewhat embarrassed about this, since this assignment was not expected to be one of teaching and demonstration. She has explained to Mr. Rossi that when his wife is permitted to come home she will be assuming her rightful role as the housewife, and Mrs. Jacobs' services will be terminated as soon as Mrs. Rossi is physically able to manage. Having visited Mrs. Rossi in the hospital and the convalescent home several times Mrs. Jacobs feels quite certain that she will not remain in the household any longer than is necessary, and that Mrs. Rossi will not expect, nor want her to. Mrs. Jacobs anticipates that Mr. Rossi may bring up the subject with the caseworker and the nurse at the time of the next visit.

* * *

Mrs. Katz, homemaker-home health aide, is caring for the two small children while the young wife, Mrs. Beckenstein, is recovering from a mastectomy. The prognosis is poor and Mrs. Katz understands that Mr. Beckenstein has been advised by the physician that his wife may not recover. Mr. Beckenstein, when applying for homemaker service, explained that he was self-employed and not doing well financially, so no fee was set. Mrs. Katz' report of the family standards indicates a very good, and probably a high income. Mrs. Beckenstein and the children need homemaker service, but she insists her husband will not pay any fee now or in the future.

* * *

Mrs. Brunetto, the homemaker-home health aide, reported that the mother, Mrs. Finazzo, suffering with a terminal illness, seems increasingly irritable and unhappy. The children, upon returning home from school, hang around the kitchen with Mrs. Brunetto and seem reluctant to spend any time in their mother's room. Mrs. Finazzo cries and yells at the children, accusing them of not wanting her any more. Then she demands unusual attention from Mrs. Brunetto just when she is preparing the evening meal. Mrs. Brunetto understands that Mrs. Finazzo is extremely fearful about her deteriorating health and expressed the wish that the caseworker and the nurse would each call at the home at least once a week.

* * *

TEAM RELATIONSHIPS, SUPERVISION, AND TRAINING CONTENT FOR HOMEMAKER-HOME HEALTH AIDES

SUMMARY:

The homemaker-home health aides report incidents involving help of children and mothers who are under psychiatric treatment. Homemaker-home health aides are members of the treatment team and look to their professional colleagues for clarification as to the meaning of behavior, and for guidance in dealing with the daily situations they encounter which are puzzling or troubling to them.

INDICATED USE:

For discussion of the team relationships and the role of the homemaker-home health aide as a person who enters into the daily life of the family members. This material could be used in training content for homemaker-home health aides and for caseworkers' and supervisors' on-the-job training sessions, as well as for administrative staff discussions for illustrating the kinds of skills needed in the selection and training of the aides.

SUGGESTED METHOD OF PRESENTATION:

Since one vignette is only three sentences it could be written on the blackboard, or with other similar short, descriptive pieces on the same topic, these could be distributed to members of the discussion group in a "problem clinic" staff development session.

Discussion could include:

...limits of the personal involvement of the homemaker-home health aide in the lives of the families served.

...understanding of the children's need for the homemaker-home health aide as a reality factor in their need for stability.

...understanding the limits of the team member's role.

...understanding what each team member will do about the mother's behavior and feelings and how each will share in planning with the aide.

...the administrative necessity for planning content of training programs which will give a degree of understanding about bed wetting, jealousy in family relationships, depression as an illness and what to anticipate in behavior of mentally ill people.

(Case illustrations on following pages)

Mrs. Watson, 35-year-old widow with seven children from 2 to 14 years of age, is receiving a public assistance grant for herself and her family. Due to her extremely poor physical and mental health Mrs. Watson is attending a series of out-patient clinics, including group therapy sessions and individual treatment from a psychiatrist. A homemaker-home health aide was placed in the home to assist in child care and household management and to try to teach Mrs. Watson, to the extent possible, how to shop, how to plan for the family's needs within the assistance grant, and how to cope with the heavy responsibility of raising seven children alone.

The case record described the living conditions in the Watson home as "intolerable" and Mrs. Watson was known to misuse her money on expensive toys and clothing for the children which were quickly ruined for lack of proper care. Mrs. Watson complained that the assistance grant was inadequate to meet the family's needs.

The homemaker spent some time in pricing necessary articles and food in the neighborhood before accompanying Mrs. Watson on their first shopping expedition. Also, she had listed with the mother's help the things which were most important to her in the way of food and clothing, after careful inventory of the children's clothes and the food supplies on hand. Mrs. Watson responded with disinterest during the planning and counting sessions but enjoyed the shopping trips and stayed within the plan, with the homemaker's help. Care of things purchased and appropriate use of them, however, was a different matter. The homemaker became discouraged upon returning to the home several weekends when Mrs. Watson had made additional purchases not within the plan, and had returned some of the children's clothing or discarded a new article by using it as a floor mop.

* * *

Mrs. Hanson, homemaker-home health aide, reports that Mrs. Ferguson seems worse again. She is vomiting almost daily and has dizzy spells. Sometimes Mrs. Ferguson just sits staring into space and does not respond to the children or to Mrs. Hanson. Her physical appearance is one of exhaustion, although she dresses neatly each morning. When Mrs. Hanson arrives in the morning she immediately makes coffee and tries to sit down at the table to sip coffee and talk with Mrs. Ferguson for a few minutes. Often then she is able to get some verbal response from her, but when Mrs. Hanson gets busy with the housework and the three pre-schoolers (after the four other children have gone to school) Mrs. Ferguson seems to "get one of her spells." Mrs. Hanson is quite puzzled that the hospital released Mrs. Ferguson when she is still so depressed. As far as she can tell the children do not seem to be upset when their mother does not respond to them. Mrs. Hanson is at a loss as to what would help Mrs. Ferguson at this time. She hates to leave the house at six o'clock knowing that Mr. Ferguson will not be home for at least another hour.

* * *

ENTRY IN A CASE RECORD --

Mrs. Sanders, homemaker, telephoned me at home tonight very upset. Mrs. Burton, Jr. has been home from the mental hospital about two weeks. Mrs. Burton, Sr., mother-in-law, continues to telephone several times a day giving Mrs. Burton, Jr. all kinds of instructions which Mrs. Burton, Jr. usually ignores. She does not know how to cope with the situation. Sometimes she tells Mrs. Sanders what her mother-in-law wants; sometimes Mrs. Sanders is able to help her meet some minor request or gives assurance that it need not be done at this time. Today Mrs. Burton, Sr. telephoned several times and apparently asked repeatedly to speak with Mrs. Sanders but Mrs. Burton, Jr. hung up. Finally Mrs. Sanders answered the phone. Mrs. Burton, Sr. was furious, saying to Mrs. Sanders, "You just wait; I'll tell my son how she hung up on me and he will get her again tonight and get her good!"

Mrs. Sanders said it seemed to her that Mrs. Burton, Jr. had a new black eye yesterday morning and more bruises on her arms today. She told Mrs. Sanders again that her husband bites her arm when she doesn't get up to take care of the children in the night when they cry. The neighbors repeatedly indicate to Mrs. Sanders that they hear Mr. Burton beating his wife nearly every night. Mrs. Sanders thinks Mrs. Burton, Jr. may be pregnant again, and reminded me that the six children, all under eight years of age, are so starved for love and affection that they increasingly show a variety of behavior problems.

* * *

Mrs. Hobart returned home from the state hospital for the mentally ill four days ago. Mrs. Nelson, homemaker-home health aide who had been assigned to the home for three months, reported that Mrs. Hobart became very upset when the children run to greet Mrs. Nelson each morning with a kiss and when they call her "Mama Nelson." This morning Mrs. Hobart grabbed Arthur, age 4, from Mrs. Nelson as she was giving him a hug, and began to whip him severely, telling the homemaker that her arrival had interrupted the mother's plan to punish Arthur for wetting the bed again.

* * *

Homemaker-Home Health Aide Service—Applications, Referrals, Terminations

CASE VIGNETTES

134/135

Mrs. Swanson was 83 years old when homemaker-home health aide service was first provided. A Scandinavian woman, she was proud and independent and insisted upon maintaining herself in her own home. She became extremely frail and fell often, yet persisted in refusing to live with her daughter in the same city. Service was begun on a once a week basis, then three days per week, and about two months later the homemaker-home health aide was permitted to come five days a week, with visits by the daughter and members of her family over the weekends. When Mrs. Swanson realized that she herself would be in control, that the agency staff members, the homemaker-home health aide and the social worker were not going to "take over" but were following her doctor's suggestions, she was gradually able to make use of the service constructively. She decided when she wanted to take a walk out of doors, when she needed help with bathing. Mrs. Swanson was maintained in her own home in this way until her death two years later.

* * *

APPLICATION --

Referral from hospital social service department: Mrs. Joyce Newman, 72 years old, has just lost her husband, Robert, 74 years old, who died after complications resulting from major kidney surgery ten days ago. Their only child, Susan, died of cancer two years ago at 40 years of age; she was unmarried. Mrs. Newman has no living relatives. She had always relied heavily on her husband, not only for companionship and management of household matters but also for his actual assistance in household duties. She is obese, diabetic, is not eating the prescribed foods and now seems depressed and unable to care for her own needs. Her doctor fears she may have a mental break.

Mrs. Newman can manage on her Social Security payments, plus income which she has from renting two rooms in her apartment. She does not give roomers any direct service, but does need to keep linens and the house clean. She also cannot look to her roomers as friends to help her in any personal way. Both work and are out of the home most of the time.

Mrs. Newman needs considerable help during this period of grief and shock. She also needs training and help in taking care of herself and managing her small income. She needs help with marketing and budget planning. A homemaker is suggested to help Mrs. Newman for at least the next two months. She cannot afford to pay a fee for this service.

* * *

AN APPLICATION --

Mrs. Ballantine, grandmother to the six Shafer children, ages 1, 2, 5, 6, 8 and 12 years, requested homemaker service while their mother, Ellen Shafer, age 32, is hospitalized. Mrs. Ballantine has cared for Nicholas, the 8 year old, and Eleanor, the 12 year old, ever since they were infants. The four younger children she has not had, and she fears they will be much too strenuous for her to manage. Also, Mrs. Ballantine has her own mother, Mrs. Longely, in the home. At the moment Mrs. Longely, 82 years of age, is in the hospital but she is due to come out within a week. Ellen Shafer will be hospitalized about ten days for psychiatric observation, Mrs. Ballantine understands. Mrs. Ballantine fears that if she attempts to take the four younger children she will herself end up in the hospital. She suffers from high blood pressure, is obese, and unable to lift the little ones.

She explained that the children's mother, Ellen, has always been irresponsible about her children and that there have been neglect charges against her more than once. The present difficulty is due to Ellen Shafer having set fire to the apartment following an argument with Mr. Willis, with whom she is living and who is reported to be the father of the two youngest children. Ellen told her mother and the police that she did this purposely in an attempt "to get him out of my life." Lt. Brown, police precinct 39, verified that Ellen Shafer will be kept under observation at Fleming hospital for at least ten days.

* * *

TERMINATION --

Mr. McKevin of DPW telephoned to ask if we wanted to extend homemaker service beyond 2/11. Explained that we did not feel it advisable. The Dawson family have managed very well this past month with Mrs. Rawlins, the homemaker, coming just two days a week. Mrs. Dawson has been prepared for termination of the service. Mrs. Dawson continues to attend the mental health out-patient clinic weekly. The two younger children seem to be adjusting very well in the day care center and the five school age children are being watched carefully by the school guidance personnel. If Mrs. Dawson does start to slip again we feel that homemaker service should be put back in, as this is definitely a family that should be maintained. Over the nearly two years we have had three homemakers in this family. Mrs. Rawlins was the first homemaker assigned on a daily basis, remaining about four months. She was then assigned to another selected family because of her special abilities with a handicapped child. Mrs. Zakowski took the assignment next with Mrs. O'Brien continuing as the relief homemaker. Mrs. Rawlins was assigned in December, when Mrs. Zakowski took leave of absence. Consequently, Mrs. Rawlins, with the caseworker, has known the family at the beginning and at the end of our period of service. All three homemakers have agreed with the caseworker that there are many strengths here. Mr. McKevin will get in touch with us if their agency notes further need for this supplementary service to the family. Homemaker service will end on the date agreed, February 11.

* * *

AN APPLICATION --

Mrs. Sullivan sat in the office of the social worker at Homemaker Service feeling almost afraid. She wished she had sent her husband; it seemed somehow easier for him to talk about Billy. She wouldn't have come at all, but Dr. Black had told her yesterday that if she didn't get to the hospital for surgery pretty soon she was going to lose her hearing entirely. She knew she couldn't hear as well as she could last month, even, but it really frightened her when Dr. Black said that. She had to be able to hear to take care of Billy; he is such a helpless little fellow. If only her husband could get off from work for a couple of weeks while she is in the hospital she wouldn't worry so much. She didn't want a strange person taking care of Billy.

The social worker was asking about the surgery, her doctor, how long she would be in the hospital -- those things were easy to answer. Now she was asking about the family, where they lived. Glen is 6 years old and in the first grade, and Billy is three. "Billy has an illness," she said, "a heart condition and a cleft palate." She felt a little bit easier now. The social worker seemed interested in Billy. She said that the homemakers are especially capable of caring for children with special problems. The social worker wanted to know more about Billy. "Billy sometimes has trouble eating, has to be fed very carefully, he's just beginning to pull himself up, but he can't walk." Mrs. Sullivan couldn't quite bring herself to say that her Billy is retarded, but how relieved she felt when the social worker asked in a matter-of-fact way if he was. She didn't seem to think it was something to hide. "Our homemakers have cared for many retarded children, in fact, they are especially interested in working with these children," the social worker said.

* * *

APPLICATION--

Referral from hospital social service department

Mr. James Swanson, 74 years old, has just been hospitalized on an emergency basis because of a critically severe attack of bronchitis, complicated by a cardiac condition. He is frantically concerned about the care of his wife, Julia, 70 years old, who is left alone at home. Mrs. Swanson is crippled with arthritis in both knees, has severely swollen legs and has not been fully ambulatory for some months. She spends most of her daytime hours in a wheel chair. Mr. Swanson has carried most of the responsibility for the household chores, although Mrs. Swanson does some things, such as ironing, from her wheel chair. They have managed frugally on their social security payments plus a small union pension that Mr. Swanson has from the garment industry. They would be unable to pay fees for homemaker services.

Mr. and Mrs. Swanson are childless, are described by their physician as being fiercely independent, and have managed without outside help throughout their lifetime. It is hoped that with a homemaker to assist Mrs. Swanson her husband could be returned home from the hospital much earlier and that continuing service might be required for approximately two months.

* * *

Homemaker - Home Health Aide Service
to the
Aged and Chronically Ill

CASE VIGNETTES ILLUSTRATING:

Helpfulness in daily living
Preserving independence of living
Preventing placement outside of the home
Providing supplementary assistance to
  responsible relatives

Mrs. O'Malley, 35 years old, cares for her two elderly parents in their own home, as well as managing her own household of four children and a husband. Her father, confined to his bed and requiring a great deal of help with toileting and dressings to change, and her mother, although ambulatory requiring close supervision because of senility, were draining Mrs. O'Malley's energies and placing an undue amount of stress on her family. Homemaker-home health aide service to her parents for two days per week permitted Mrs. O'Malley a much needed rest and change, and the satisfaction of continuing to carry her family responsibilities which were important to her and to her parents.

* * *

Mrs. Mason, at 95 years of age, could hear a loud voice only in her left ear. Her eyesight was dim, she was none too steady in walking, but managed to get to her doctor's office unescorted. Her mind was extremely alert and her independence and Victorian stoicism were sometimes a cause for concern. Resistance to accepting her increasing physical limitations was exhibited by condescending to carry her cane, but not to use it. Upon her physician's advice she accepted the visit from the visiting nurse, treating her with reserved friendliness, somewhat as a "necessary" guest.

Eventually a homemaker-home health aide was successful in establishing a relationship with Mrs. Mason, calling every day for a time, and staying for half an hour or so to perform a specific chore. Then on a half-day basis on week days only. The suggestion of a grab bar in her bath tub was rejected until the homemaker-home health aide persuaded her to look at one. Since it was not a permanent fixture it was finally accepted. The homemaker-home health aide field supervisor was told, "One does not come to call uninvited, much less to treat me like a child."

* * *

Mrs. Schmidt, 79 years old, went to a nursing home upon the advice of her physician, but was extremely unhappy and returned to her own home. Referred to the VNA by the doctor, Mrs. Schmidt was maintained at home under an appropriate plan with a homemaker-home health aide assisting with personal care, shopping, meal preparation and light housekeeping on a four hour, three day a week basis.

* * *

Mr. Mason, 90 years old, lives alone with his cat Elijah. He has never married and has no relatives in this country. Although he experienced no accident his generally weakened condition with advancing age was a worry to his neighbors. Through referral from his church where members agreed to take care of his meals and heavy household tasks over the weekends, Mr. Mason was maintained at home by the placement of a homemaker-home health aide every afternoon, Monday through Friday.

* * *

Mrs. Lewis, 84 years old, fell, fractured her nose and sustained numerous bruises. A homemaker-home health aide called daily and prepared the noon meal for the Lewises and assisted Mrs. Lewis with personal care, undertook some shopping and laundry chores with Mrs. Lewis' participation. Two weeks later Mr. Lewis, 88 years old, fell, fortunately did not break any bones but was badly bruised and found it difficult to get about. For six more months Mr. and Mrs. Lewis were sustained in their own home through the services of the aide. Eventually they were persuaded to make their home with a relative.

* * *

When Mr. Simons heard his wife tell him she had been discharged and could go home, he came out of her hospital room with tears in his eyes and asked the floor nurse, "What am I going to do? I can't take care of her."

Both Mr. and Mrs. Simons were in their early 80's. She had fractured a hip, was very weak, completely bedridden and had severe bedsores. They lived with Mrs. Simons' sister who was an amputee. The nurse called the Visiting Nurse Association Coordinator and asked her to talk to them. A referral was made and under medicare, home health aide service was planned.

Now, months later, the aide, Mrs. Rogers, is no longer needed. The sister has gone to a nursing home, a niece helps with some of the housework. Mrs. Simons can manage some personal care and is walking with full weight bearing.

Their gratitude for being able to stay together in their own home is shown in the sparkle in their eyes and their renewed interest in life. They greet the nurse on her visits with more vitality. They often ask, "What would have happened to us without Mrs. Rogers?"

* * *

Mr. Harmon, 88-year-old retired university professor, has continued to live alone since his wife's death seven years ago. A son, an attorney, and a daughter, a school teacher, have been unable to persuade Mr. Harmon to live in either of their homes. Following hospitalization Mr. Harmon needed careful supervision of his diet, some help in skin care but he steadfastly maintained that he would continue to live in his own home. A homemaker-home health aide was assigned to assist Mr. Harmon daily at first and then on a three times a week basis, with family members carrying shopping, laundry and other responsibilities during the other days. This plan, with Mr. Harmon paying for the service, was followed for a three year period, thus permitting him to remain as independent as possible and without hospitalization for that length of time.

* * *

Mrs. Miller, 62 years old, is described as medically blind and very deaf. A hearing aid prescribed many years ago was such an unsatisfactory appliance that Mrs. Miller has refused to try one again. Her blindness is a new disability, but because she lives in the same apartment she has been able to manage quite well until recently. She lives alone in the center of the city. Her two married children live in the suburbs. One grandson, married, lives nearby but his working hours prevent his being of assistance to Mrs. Miller for her marketing, banking and other business errands. The superintendent of the apartment house cashes Mrs. Miller's checks each month and does some of the food marketing for her. There seemed to be some evidence that perhaps Mrs. Miller was being short changed by these arrangements.

A homemaker-home health aide was assigned to assist Mrs. Miller on a three half-day a week basis, later changed to one half-day each week, and escort service to clinics as needed. Planning with family members, Mrs. Miller, and the all too helpful apartment house superintendent, the homemaker-home health aide escorts Mrs. Miller to the bank, assures her correct change in her business procedures and plans household management matters with her.

* * *

The American Cancer Society referred the Jablonski family for homemaker-home health aide service. Two teen-aged children attended high school, the father was steadily employed and Mrs. Jablonski was bedfast except for bathroom privileges. A nurse from VNA visited twice weekly for personal care. Medication was self administered. Mrs. Jablonski had returned from the hospital after extensive treatment for metastatic cancer.

Heavy financial burdens because of the medical expenses resulted in the Jablonski's losing their suburban home and moving to a second floor apartment in the old section of the city. The medical bills persisted and soon the family was in such financial difficulties that utilities were suspended.

On three occasions Mrs. Jablonski attempted suicide, twice with drugs and once by cutting her wrists. The first time she took the drugs the homemaker-home health aide found her in a stupor and was unable to arouse her. Thereafter, with VNA approval, the aide recorded drug administration when she was in the home. The other attempt occurred over weekends when the family was at home.

Budgeting and money management counseling with the high school children and the father were carried out jointly with the caseworker and the homemaker.

* * *

Mr. Waverly, 64 years old, had a below-the-knee amputation, necessitated by a circulatory disturbance. The amputation was a terrific blow to his pride and self-confidence. When he was discharged from the hospital to return to his trailer, where he lived alone, a referral to the Visiting Nurse Association was made with a request for homemaker-home health aide service to encourage Mr. Waverly to do what he could for himself. The aide was to encourage the use of the prosthesis and to see that he ate three balanced meals a day. The hospital predicted the nurse and the aide would find Mr. Waverly in bed when they called, and they did.

Daily service was planned at first, and gradual withdrawal planned as Mr. Waverly began to make progress in the use of the prosthesis. Mrs. Hamline, the homemaker-home health aide, was very sensitive to his needs, interceding when he needed her help and sensing when to have him do for himself. Mrs. Hamline's daily schedule was reduced to three, then two times each week. The visiting nurse continued to visit for a while after the aide's services were terminated, and at her last visit Mr. Waverly announced that he had taken his car out and gone for a drive. His parting words were, "I'm so proud."

* * *

A homemaker-home health aide was assigned by the Council's Project on Homemaker-Housekeeper Service for the Chronically Ill and Aged to care for a frail, worn mother, 79, crippled with arthritis, and her daughter, 56, terminally ill with cancer.

In the two days a week the homemaker-home health aide is with them, she helps with meals, does laundry, shops, and gives some personal care to both women, under instruction from the visiting nurse. Besides preventing institutionalization, the lightening of physical burdens has meant an easing of emotional tensions between mother and daughter. Equally important, says the caseworker, is the "tremendous mental lift" the homemaker has given. Both mother and daughter tell the nurse and the caseworker "You've sent us an angel."

* * *

A homemaker-home health aide, Mrs. Peterson, was placed in the home of a 44-year-old mother terminally ill with cancer. Mrs. Bundy was very ill, emaciated and weak from vomiting the little food she forced herself to eat. Her two daughters, Mollie, age 17, and Bess, age 11, had been told by their father and the doctor of their mother's approaching death. But Mrs. Bundy told Mrs. Peterson that "the girls ignore me, they act as though I'm not really sick; even my husband ignores me. I know he must work long hours but sometimes I think they all prefer not to have me around." She also said to the visiting nurse, "It is important to me to know as much as I can about what to expect. When am I going to die? How will it come? How will it feel?"

Mrs. Peterson, the aide, shared her feelings with the nurse and the social worker. It troubled her that the daughters came home from school, rushed to their mother's room for all of ten minutes with very animated talk of their school and social life, then dashed off again with seemingly little concern for Mrs. Bundy's weakened condition.

Mrs. Bundy died one morning after the girls had gone to school, twenty-two days after homemaker-home health aide service had begun. Mrs. Peterson remained in the assignment for several more days until the father and the girls made other plans, because she and her team members, the social worker and the nurse, knew that Mollie and Bess needed to have her there as a supportive strength during this trying period.

* * *

Homemaker - Home Health Aide Service
to
Families with Children

CASE VIGNETTES ILLUSTRATING:

Flexibility in the use of the service

Assistance in evaluating
complex family problems, including
neglect and abuse of children

Teaching household management
and child rearing responsibilities

When their twin boys were just five months old Mrs. Kennedy had a mastectomy. The doctor referred the family to the Cancer Society, saying the prognosis was extremely poor. Besides the twins the Kennedys' had three older children, and Mr. Kennedy, a city policeman, in going over the family relationships could think of no relatives who could assist him during this crisis. Although both had sisters and brothers living in the city each family had heavy and pressing responsibilities.

A homemaker-home health aide was placed in the Kennedy home for eight hours, seven days a week. After six weeks this was changed to a six hour day, five days a week, as Mr. Kennedy was able to secure baby-sitting services from a teen-age niece.

Mrs. Kennedy was returned to the hospital a few months later and died. Mr. Kennedy had an emergency abdominal surgery one week after his wife's death. Through these crises the homemaker-home health aide service was increased again and for about two weeks twenty-four hour service was given. The Kennedy children were able to remain in their own home, under the care of trusted and known "mother substitutes."

* * *

Mr. and Mrs. Novotny, 28 and 23 years of age respectively, have three little boys, 5, 2 and 1 years old. During Mrs. Novotny's pregnancy for their fourth child she was diagnosed as suffering from multiple sclerosis. The Novotnys were both extremely worried about their situation. Mrs. Novotny was in much pain and experienced increasing locomotive difficulties. Mr. Novotny lost his job, and was able to find only a six hour job at a local theatre. He requested manpower development training.

A homemaker-home health aide was placed in the home on a ten-hour daily basis, seven days a week. This meant that two homemakers worked with the family, and even a third as a relief homemaker over weekends. The doctor prescribed complete rest for the young mother.

Mr. Novotny was referred to the course for training taxi cab drivers and passed the course successfully within a short time. He secured a full time job as a driver and continued to take responsibility for the family shopping, planning for the purchases with the "morning" homemaker. When the baby was born the couple released their fourth little boy to an adoption agency. The homemaker-home health aides, as well as the social worker provided much needed psychological and physical supports to the young family throughout this ordeal. The multiple sclerosis society gave counsel to the team members working with the family. A day care program was worked out for the five year old.

The agency anticipates that services will continue probably for several years, with Mr. Novotny paying toward the service if steady employment and wages assure adequate maintenance for the family without the need for public assistance.

* * *

Mrs. Riley was an excellent mother and wife, giving fine care to her husband and their eight children, all under the age of ten. Mr. Riley provided a comfortable living for his family. Their home was attractively furnished and showed evidence of fine cultural interests. Then, as a result of Mr. Riley's long hospitalization with a terminal illness, the family was forced into dependency on public assistance. Mrs. Riley, in a late stage of pregnancy, became distraught. She spent most of her time at the hospital, leaving the children unattended after she had become estranged from her sister who lived nearby and usually helped by baby-sitting.

The agency caseworker planned cooperatively with the agency Homemaker Service for the placement of a homemaker to maintain as many normal routines as possible for the bewildered children; to give Mrs. Riley an opportunity to be with her husband with a lessening of some of the stress; and to offer her assurance that someone was concerned about the family misfortune. A homemaker was carefully selected and prepared for eight-hour a day service to the family.

Mrs. Riley and the children related well to the homemaker during the first month of the service. At the end of this period Mr. Riley died and Mrs. Riley gave birth to a healthy ninth child. These two events precipitated severe emotional upset and physical regression in Mrs. Riley.

Twenty-four hour homemaker service was begun, as well as psychiatric consultation for Mrs. Riley. As Mrs. Riley gradually regained her capacities, the family case worker, psychiatric consultant, agency medical consultant, homemaker supervisor and homemaker worked closely on the approaches and timing of preparation for her future planning.

There was a return to eight-hour homemaker service. The case worker was able to assist in effecting a reconciliation between Mrs. Riley and her sister. The sister took advantage of opportunities to observe the homemaker's service, and was finally willing and successful in continuing the needed temporary services for the family.

* * *

Mrs. Townsend, homemaker, said it is very hard to explain to the little ones about their mother's death. Billy, age 5, asks nearly every day when his mother will come home "from heaven." Bobby, age 6, asked if she isn't going to come to get all the clothes she left at home and take them to heaven with her. The older sister told the little ones that heaven is the place where sick people go to be relieved of their illness and pain. One night when it was raining, Marie, age 4, looked up in the sky and said, "Rain, is my mother feeling well now?"

* * *

Mrs. Collins, 33 years old

6 children -- 12 years to 4 years

Mrs. Collins was described in the agency record as an inadequate mother. Neglect charges were made repeatedly because the children had been found alone in the home without supervision. The home was said to be filthy, the children usually dirty and their clothing ragged. Schools reported uneven attendance and poor school achievement for the four school-age children.

Homemaker service was begun two half days per week. The charge to the homemaker was to establish a firm, "big-sister" relationship with the mother, to encourage Mrs. Collins to get away from the house occasionally, but never to leave the children unattended. Shopping and planning meals, cooking and baking were planned together. Laundry, mending, and care of clothing was stressed.

After two months Mrs. Collins enrolled in a Nurse's Aid Course which she passed with a high grade. Both she and the children were very proud. She wanted to work in a hospital or nursing home, and this she planned to do when her youngest child would be in school full time.

When summer came, and the children were all home from school, homemaker service was discontinued. This proved to be a mistake, for by September the home conditions had not been maintained up to standard and homemaker service was again instituted. At this point Mrs. Collins decided she would like to go to work without waiting for her youngest to be in school.

* * *

Following the birth of their sixth child, with the oldest being but seven years of age, Mrs. O'Malley developed phlebitis in her left leg and became very depressed. Her mother had died with "a blood clot" following childbirth. Mrs. O'Malley was transferred to the hospital psychiatric unit with a diagnosis of post-partum depression. When discharged her physical activity was limited and her mental health did not permit full family homemaking responsibilities. A home health aide was assigned to assist with child care and housekeeping, and Mr. O'Malley, who had been off work for five weeks during the family crisis, was able to return to work.

About three weeks later Mrs. O'Malley was able to assume most of her family and household responsibilities and her mental health was greatly improved. The homemaker-home health aide service was reduced to a half day, twice a week but provided continuity in maintaining normal household management. Mrs. O'Malley is soon to return to the hospital for a vein ligation. The aide will remain with the family throughout the mother's hospitalization and convalescence at home and until she is back on her feet. Six pre-school children, an active first grader, and a hard-working husband and father with a low income will continue to experience a service preventive of family breakdown, and protective of their daily needs and the mother's mental and physical health.

* * *

Mr. and Mrs. Lorenzo are in their early thirties. They have eight children ranging in age from 11 years to the one-year-old baby. Following a hysterectomy, the mother was institutionalized in the state mental hospital, but was returned home rather soon. She was unable however to carry on her housekeeping duties without assistance.

Mr. Lorenzo, a small, proud man seems to want to work, but he is undereducated and his jobs rarely pay enough to make them worthwhile. Mrs. Lorenzo pushes and nags and as a result he seems to become even more discouraged, and "takes off with the boys" for awhile, sometimes for two or three days.

The household conditions were described as deplorable. Neither of the parents appeared to know much about child-rearing, the youngsters presented a number of problems in school and in the neighborhood, and complaints of neglect have been made. The mother appeared to be living in a dream world much of the time, was not a good shopper or manager, did not serve regular meals to the children, but bought them frivolous clothing and toys when Mr. Lorenzo did bring home a paycheck.

Planning with the family, a training program was worked out for Mr. Lorenzo. A homemaker-home health aide was assigned to assist the overburdened mother. It was hoped that the aide could teach something about household management, including money management, child-rearing and discipline, as well as give Mrs. Lorenzo a psychological boost and keep her attending the mental health clinic regularly. It also seemed important to encourage the mother to get out of the house a few hours each week. A day care plan was worked out for two of the small children to reduce some of the strain and effort for the mother on the days when the homemaker was not there, and to provide the children with an educational experience, special attention and care outside of their crowded home.

Three-times-a-week service was reduced in a short time when it appeared that Mrs. Lorenzo wanted to treat the homemaker-home health aide as a household maid, with little appreciation for her assistance and negation of the teaching role. Later after the treatment team consisting of the homemaker, the mental health clinic caseworker, the psychiatrist, and the homemaker supervisor conferred, the Lorenzos were brought more clearly into the plan. Another homemaker was assigned, and a fresh start made with two days a week and a half day when Mrs. Lorenzo had a clinic appointment. Mr. Lorenzo is continuing in school. Mrs. Lorenzo is alternately discouraged and depressed, and then abusive to Mr. Lorenzo and neglectful of the children.

* * *

Mrs. Bierman told the caseworker, "I need help quick and fast. I've got to get away from these kids."

Mr. Bierman's sister had reported the situation, charging neglect and abuse of the children by both parents. Mrs. Bierman seemed distraught, but eager to talk to the caseworker.

After the homemaker-home health aide was placed in the home on a six-day a week basis, hours 8:30 a.m. to 5:30 p.m., a careful record was kept of the children's bruises and possible beatings. The five children (the oldest just six years of age) seemed to be continually covered with scratches, burns and bruises of one kind or another. Bobby, the three year old, seems to be the particular target of his mother's anger, the aide reported. His mother screams at him that he is "ugly, get out of my sight." However, Mrs. Bierman dutifully takes whatever child seems to be the most hurt to the hospital at the homemaker's insistence. The hospital clinic's records showed that Bobby was brought in more often than any other child with what appeared to be burns on arms, buttocks, cuts on head and chest, legs and arms. One day the homemaker-home health aide, Mrs. Thompson, reported that Mrs. Bierman screamed at Bobby that she would "blacken your other eye so you'll wind up in the hospital where you belong." When the aide telephoned, the caseworker came to the home immediately. Mrs. Bierman told the caseworker that her five children by her first marriage to William Pearson were all taken away from her and placed by a children's agency in Boston.

DPW decided to take the case into court and the homemaker agreed to testify, too. Throughout the hearing Mrs. Thompson, the homemaker, sat with Mrs. Bierman and often held her hand. Mrs. Bierman repeated to her over and over again, "You don't know what it's like, you don't know what it's like, but none of you know what it's like?"

* * *

Major Sources of Information

NATIONAL COUNCIL FOR HOMEMAKER SERVICES, INC.

1740 Broadway
New York, N. Y. 10019

The Council (NCHS) was established in 1962 under the sponsorship of the National Health Council and the National Social Welfare Assembly, with the endorsement of many other national health and welfare agencies and governmental departments and bureaus. Membership is open to agencies providing homemaker-home health aide service and to organizations and individuals interested in supporting the Council's work.

NCHS serves as a clearing house for information about all aspects of homemaker-home health aide service, publishes reports, and distributes educational and promotional materials. It provides a library loan service of pertinent materials published in the field, and serves as the official representative for organized homemaker-home health aide services in the United States through membership in the International Council of Home Help Services.

Publications — NEWS, usually a four-page leaflet, published five times a year by NCHS in alternate months (except for August) with

HOMEMAKER-HOME HEALTH AIDE BULLETIN, published six times a year by the American Medical Association in cooperation with the NCHS.

These news bulletins, distributed without cost to a mailing list which together reaches approximately 7,000 people, serve to keep the membership of NCHS, selected health and welfare agencies, and interested individuals informed about developments in the organized services providing homemaker-home health aides.

Basic documents recently published by NCHS are listed below; other materials are listed in the bibliography.

STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES
Published in 1965, this 48-page book is available from NCHS for $1.00. It was prepared by a committee on which served representatives from government units, national health and welfare organizations, professional associations, and many experienced practitioners in the field. Sometimes referred to as The Code, this book of standards enunciates the principles formulated over the years in developing and operating homemaker-home health aide services.

DIRECTORY OF HOMEMAKER-HOME HEALTH AIDE SERVICES, 1966-67.
This issue of 181 pages is available from the NCHS for $3.00. It lists approximately 800 organized homemaker-home health aide services throughout the United States and Canada, and includes Puerto Rico. This directory was developed in a joint project by the Bureau of Family Services, Welfare Administration, U.S. Department of Health, Education, and Welfare, and the NCHS. Production of the directory was one of the responsibilities assumed by the NCHS when it was established in 1962.

A TRAINING MANUAL FOR HOMEMAKER-HOME HEALTH AIDES
Developed by the National Council for Homemaker Services in 1967 under the auspices of the Office of Education, U.S. Department of Health, Education, and Welfare, this document of 190 pages is available to members of NCHS for $3.00, to non-members for $5.00. It contains ten units of instruction with teaching source material and suggested learning experiences geared to the educational objectives of each unit.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Washington, D. C. 20201

Over the years many units of this department have been active in providing leadership in the development of homemaker-home health aide services. Initially viewed mainly as a child welfare service the Children's Bureau published some of the first guides ever issued for the use of public and voluntary social agencies in establishing and operating community programs of homemaker services. As new legislation became effective other units of the Department took additional responsibilities, particularly the Public Health Service for leadership in home care programs for the aged, the chronically ill and the disabled, emphasizing preventive medicine and restorative care through such programs. Following the 1962 public welfare amendments to the Social Security Act, the Welfare Adminstration and its integral units including the Bureau of Family Services, promoted the expansion and strengthening of homemaker-home health aide service as a crucial and vital program for preventive, protective and rehabilitative services to families and individuals. Stressing the need for both quality and quantity services the Welfare Administration through its Bureaus provided consultation by specialists in homemaker-home health aide service to state departments of public welfare. Currently the Social and Rehabilitative Service of the Department continues a leadership role in stimulating the expansion of these programs.

The three major divisions of the U.S. Department of Health, Education, and Welfare now giving leadership to this field are:

Office of Education, 400 Maryland Avenue, S.W. Washington, D.C. 20202
Public Health Service, 9000 Rockville Pike, Bethesda, Maryland 20014
Social and Rehabilitation Service, 330 Independence Avenue,
S.W. Washington, D.C. 20201

Department publications, for many years a major reference source in the field, are listed in the bibliography. Pamphlets and brochures for public information are distributed widely, and inter-departmental memoranda and "state letters" provide detailed guides to public health and welfare agencies beginning or operating homemaker-home health aide services.

INTERNATIONAL COUNCIL OF HOME HELP SERVICES

For information write to the U.S. representative: National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019

A permanent secretariat of the International Council of Home Help Services (ICHS) has not been established and there is no employed staff. The Secretary General is an elected officer who serves a limited term of office. "Home helps", the term for homemaker-home health aides in Great Britain, have been used throughout European countries since the end of the 19th century. Known by various names such as "housewife reliefs", "child reliefs", "homemakers", "social assistants", these specialized workers have markedly increased since World War II.

Several international meetings and conferences culminated in the proposal for forming an international council, made at an invitational conference held in Oxford, England, in October 1956 under the sponsorship of the British Institute of Home Help Organizers. Delegates from 15 countries attended and the Council was formalized as an international organization at a meeting in Holland in 1959.

The major purpose of the ICHS is to "make the work of the home help service known to those countries who either have no services or undeveloped services" and to sponsor the International Congress on Home Help Services to further the exchange of ideas and stimulate the growth and professionalism of such programs. Its only publications to date have been the proceedings of the 1962 and 1965 international meetings. Attendance at these meetings have included representatives from Thailand, Japan, Israel, Canada, and the United States as well as representatives from nearly all European countries. The English translations of the conference reports, however, were published by the U.S. Department of Health, Education, and Welfare.

OTHER SOURCES

In addition to the major sources listed above information about homemaker-home health aide services in particular settings may be secured from the organizations listed below:

American Cancer Society, Inc.	219 East 42nd Street New York, N. Y. 10017
American Home Economics Association	1600 Twentieth Street, N.W. Washington, D. C. 20009
American Hospital Association	840 North Lake Shore Drive Chicago, Illinois 60611
American Medical Association	535 North Dearborn Street Chicago, Illinois 60610
American Nurses' Association, Inc.	10 Columbus Circle New York, N. Y. 10019
American Public Health Association	1740 Broadway New York, N. Y. 10019
American Public Welfare Association	1313 East Sixtieth Street Chicago, Illinois 60637
Association of the Junior Leagues of America	305 Park Avenue New York, N. Y. 10022
Canadian Public Health Association	1255 Younge Street Toronto, Ontario, Canada
Canadian Welfare Council	55 Parkdale Avenue Ottawa, Canada
Child Welfare League of America	44 East 23rd Street New York, N. Y. 10010
Family Service Association of America	44 East 23rd Street New York, N. Y. 10010
Gerontological Society	660 South Euclid Avenue St. Louis, Missouri 63110
National Association for Mental Health, Inc.	10 Columbus Circle, New York, N. Y. 10019
National Council on the Aging, Inc.	315 Park Avenue South New York, N. Y. 10010
National League for Nursing, Inc.	10 Columbus Circle New York, N. Y. 10019
National Rehabilitation Association	1029 Vermont Avenue, N.W. Washington, D. C. 20005

Annotated Bibliography
Selected References

ADMINISTRATION, ORGANIZATION AND FINANCING

Brodsky, Rose. "Administrative Aspects of 24-Hour Homemaker Service," Child Welfare, Vol. 45, No. 1 (January 1966), p. 34.

A description of a program under the auspices of a voluntary agency but whose services are purchased from a public agency, this article gives straightforward advice about many aspects of administering an around-the-clock program. Many of the suggestions are applicable for a daytime service program as well, although this program was designed to prevent emergency placement of children away from their own homes.

Bureau of Family Services, Welfare Administration. "Guides for the Administration of Homemaker Service in Public Assistance Programs", Homemaker-Home Health Aide Services in Public Assistance Programs, State Letter 910, Washington, D. C.: U.S. Department of Health, Education, and Welfare, 1966. 14 pp. (Available from the Department, Washington, D. C. 20201.)

Issued as Attachment B to State Letter 910, this guide interprets policy for implementing programs by local departments of public welfare. It also describes the essential steps in administrative planning for the development of homemaker services.

Division of Chronic Illness Control, New Jersey State Department of Health and Visiting Homemaker Association of New Jersey. Statistics and Costs for Visiting Homemaker Services in New Jersey. Trenton: New Jersey State Department of Health, 1963. 28 pp. (Available from the Department on request.)

This is a manual for reporting basic statistics and costs and for compiling and reporting statistical information on the service. Sample forms are interspersed with the text.

Doscher, Virginia. "Marshalling Team and Policies for Good Administration," Report on the 1964 National Conference on Homemaker Services. New York: National Council for Homemaker Services, Inc., 1964. 76 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00)

The emphasis in this chapter of the report is on community planning, the interdependence of services, and the participation of a variety of agencies and professional disciplines. Essentials in administration which are considered broadly applicable are discussed.

"Determining Costs and Meeting Them," Report of the 1964 National Conference for Homemaker Services, Inc., 1964. 76 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00)

A discussion of the direct and indirect expenses of operating a homemaker-home health aide service, and of the various sources of financing, including fee payments by users of the service, is the focus of this chapter of the national conference report.

Mandalfino, S. A. Potentials of a Centralized Community Homemaker Service: The Cleveland Experience. New York: The National Council for Homemaker Services, 1967. 20 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00.)

This publication is that of one paper presented at the 94th Annual Forum of the National Conference on Social Welfare, 1967. It describes in some detail the organization, structure and beginning operation of a centralized community homemaker-home health aide service.

North Carolina State Department of Public Welfare. Homemaker Service in Public Welfare--The North Carolina Experience. Washington, D. C.: U. S. Department of Health, Education, and Welfare, 1965. 48 pp. (Single copies available from the Department, Washington, D. C. 20201.)

Originally printed in 1961 as one of the "How They Do It" series, this pamphlet was revised and updated for its 1965 printing. It contains suggested guides implicitly stated for the development of a state wide program under the administration of county departments of welfare and supervision of the state agency. Administrative criteria for staffing, duties and responsibilities of the aide, some guides for training aides on the job, scheduling, and placement are all included. Examples of the kinds of families and individuals served indicate the usefulness and flexibility of the service, as well as its value.

"Organization and Administration of Homemaker Service" in CWLA Standards for Homemaker Service for Children. Prepared by the Committee on Standards of Homemaker Service, Child Welfare League of America, New York: The League, 1959. 45 pp. (Available from the League, 44 E. 23rd Street, New York, N. Y. 10010. $1.25.)

This section of "the standards" written and developed for child welfare agencies includes such matters as auspices, agency policies and procedures, staffing and qualifications for staff members, work loads, personnel practices, record keeping and inter-agency agreements for purchase of the service.

"The Staffing of a Homemaker-Home Health Aide Service: recruitment and selection of homemakers, qualifications and responsibilities of homemakers, professional and clerical staff, consultants and volunteers", in Standards for Homemaker-Home Health Aide Services (Chapter IV, pp. 21-32) Prepared by the Committee on Standards, National Council for Homemaker Services. New York: The Council, 1965, 48 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00.)

This chapter enunciates principles to follow in the administration of the service with regard to staffing the program. Much of the material in this chapter suggests guides for developing job descriptions and job specifications as required in sound personnel administration.

BIBLIOGRAPHIES

Colorado State Department of Public Welfare. "Homemaker Service --A Bridge to the Future," The Library Counselor, Vol. 21, No. 2 (April 1966). 34 pp. (Available on library loan from the National Council for Homemaker Services, 1740 Broadway, New York, N.Y. 10019. Purchase from the Department, Denver, Colorado 80203. $1.00)

This is an annotated bibliography, listing reference material on the subject under headings such as "background and general information," "meeting special needs -- children, aged and chronically ill," "recruitment, selection and training of homemakers." It contains an index of authors.

Edwards, Mabel I. Selected References on Home Care Services for the Chronically Ill and Aged -- An Annotated Bibliography. Iowa City, Iowa: Institute of Gerontology, University of Iowa, 1967. (Available on library loan from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019. Purchase from the Institute of Gerontology.)

This document is in four sections: Coordinated Home Care, pp. 1-22; Homemaker-Home Health Aide Service, pp. 33-98; Meals on Wheels, pp. 99-108; and Dental Home Care Services, pp. 113-127. Each section contains general information regarding major sources of information on its subject. The book was compiled for use largely in Iowa but provides general descriptive material and information on various program aspects, particularly listing the conferences held on home care and homemaker services, special reports and studies not in general circulation, and their sources. Most of the references listed were published from 1960 to the first few months of 1967.

Morlock, Maud. Homemaker Services -- History and Bibliography, Children's Bureau Publication No. 410. U. S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, Washington, D. C.: U. S. Government Printing Office, 1964. 116 pp. (Available from Superintendent of Documents, Washington, D. C. 20402. Price $.40.)

This annotated bibliography contains historical materials listing the extant published material relating to homemaker services in all the fields concerned with these services. Generally, mimeographed materials and articles appearing in popular journals are not included. It also contains materials in English descriptive of homemaker-home health aide services in other countries. A chapter on the history of the service in the United States from its beginnings in Philadelphia in 1903 to the date of the book's publication reflects the leadership of the Children's Bureau in establishing and expanding homemaker service programs.

CONFERENCE REPORTS AND PROCEEDINGS

1959 National Conference on Homemaker Services, February 10-11, 1959, Chicago, Illinois.

Homemaker Services -- Report of the 1959 Conference, Public Health Service Publication No. 746. Division of Public Health Methods, Public Health Service, U. S. Department of Health, Education, and Welfare. Washington, D. C.: U. S. Government Printing Office, 1960. 257 pp. (Available from the Superintendent of Documents, Washington, D. C. 20402. $1.25. Also available in libraries and state public health and welfare departments.)

Stimulated by a request for a conference from the National Committee on Homemaker Service, the Children's Bureau took the initiative in drawing together 26 national voluntary organizations and 8 units of the U. S. Department of Health, Education, and Welfare to sponsor the conference jointly. Its purpose was that of stimulating the development of homemaker services throughout the United States. Delegates from 35 states, the District of

Columbia and Canada numbered 300. The proceedings include five major papers given at the conference in Part II, while Part I has chapters covering the deliberations on topics such as financing, planning and recommendations.

1960 Annual Meeting, National Committee on Homemaker Service, October 13-14, 1960, New York, N. Y.

Proceedings -- Annual Meeting, National Committee on Homemaker Service, National Committee on Homemaker Service. New York: The Committee, 1960. 51 pp. (Mimeographed.) (Available on library loan basis from the National Council for Homemaker Service, 1740 Broadway, New York, N. Y. 10019.)

Four of the papers presented at this conference are included in this document, each of the authors having contributed to the development and expansion of the service. Summaries of the eight workshops are also included.

1960 Arden House Conference on Personal Care in Homemaker Service, February 14-16, 1960, Harriman, New York.

"Report of Conference on Personal Care in Homemaker Services," Homemaker Services Bulletin, Vol. 1, No. 4 (July 1960) pp. 1-4. (Available from the American Medical Association, 535 N. Dearborn, Chicago, Illinois 60610. Also a reprint made in 1967 is available in pamphlet form from the Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C. 20201.)

This conference was sponsored by the National Health Council and was recommended by the delegates to the 1959 National Conference on Homemaker Services. Its focus was that of completing some of the unfinished business of the 1959 conference. This report contains guidelines regarding the kinds and degrees of personal care which would be appropriately the responsibility of the homemaker-home health aide, under the guidance of medical personnel. The conference concludes that "in general, the homemaker may be taught those procedures that family members would ordinarily perform ... the homemaker should not be permitted to decide by herself what personal care services she will give ... decisions should be made case by case."

1962 International Congress on Home Help Services, September, 1962, Paris, France.

Proceedings of the International Congress on Home Help Services, 1962. English translation, Welfare Administration, U. S. Department of Health, Education, and Welfare. Washington, D. C.: U. S. Government Printing Office, 1962. 71 pp. (Available from the Superintendent of Documents, Washington, D. C. 20402. 30 cents. Also available from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019.)

This document contains five major papers given at the Congress, and brief resumes of "Home Help" organizations from eleven European countries, Canada and Japan. Delegates and the members of the planning committee are listed.

1964 National Conference on Homemaker Services, April 29-May 1, 1964, Washington, D. C.

Report of the 1964 National Conference on Homemaker Services, written by

Virginia Doscher, New York: National Council for Homemaker Services, 1964. 76 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00)

The 80 papers presented at the conference are synthesized in this report under topical headings such as administration, training, financing, and personnel policies. The conference was a joint effort between the Council and units of the U. S. Department of Health, Education, and Welfare, voluntary organizations and the American Medical Association.

1965 International Congress on Home Help Services, September 1965. Koenigstein, Germany.

Proceedings of the International Congress on Home Help Services, 1965. English translation, Welfare Administration, U. S. Department of Health, Education, and Welfare. Washington, D. C.: U. S. Government Printing Office, 1965. 102 pp. (Available from the Superintendent of Documents, Washington, D. C. 20402. 35 cents. Also available from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019)

This congress had a theme, "Home Help -- A Modern Social Profession." The report contains summaries of the work groups, and nine major papers presented at the congress are included.

1966 International Conference of Social Work, September 1966, Washington, D. C., U.S.A.

Urban-Development, Its Implications for Homemaker-Home Health Aide Services. A session was held on September 8, 1966, for delegates to the international conference who were interested in these specialized services. No proceedings were planned for publication, but three of the papers given at this one day meeting were to appear in the Homemaker-Home Health Aide Bulletin.

"Training for Homemaker Services" by Clara Ottesen of Norway appeared in Vol. 8, No. 5 (September 1967).

"Purpose, Function and Work of the International Council of Homehelp Services" by Dr. Carmen Jonas of Germany and "The Contribution of Homemaker Service Toward Meeting Needs of People in an Urbanized Society" by Dr. Ellen Winston of U.S.A. are planned for publication in Volume 9, 1968.

1967 Annual Meeting and Forum, National Council for Homemaker Services, May 4-5, 1967, New York, N. Y.

Report of 1967 Forum on Homemaker-Home Health Aide Service, written by Evelyn Hart. New York: National Council for Homemaker Services, 1967. 32 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.50.)

"Current Realities and Future Opportunities for Homemaker-Home Health Aide Service" was the theme of the first annual forum held by the Council in conjunction with their fifth annual meeting. The keynote speaker, Dr. Ellen Winston, presented a paper with the same title. The published report is an organized condensation, under subject groupings, of the various papers and workshop discussions.

1968 Annual Meeting and Forum, National Council for Homemaker Services, April 25-26, New York, N. Y. National Council for Homemaker Services (Available from the Council, 1740 Broadway, New York, N. Y. 10019 $1.50)

Report of 1968 Forum on Homemaker-Home Health Aide Service

The Theme: Homemaker-Home Health Aide Service in Action. This report summarizes principal papers, workshop discussions.

DESCRIPTIONS OF HOMEMAKER-HOME HEALTH AIDE PROGRAMS

Aldrich, C. Knight. "Homemaker Service in Psychiatric Rehabilitation," American Journal of Psychiatry, Vol. 114, No. 11 (1958), pp. 993-997.

Dr. Aldrich, child psychiatrist, describes the use of homemaker services as a protective, rehabilitative and preventive service in family situations, usually where the mother is mentally ill and the children suffer inevitably from separation and loss of maternal support. The author lists six criteria for determining the use of homemaker service as the best plan for the children.

Aldrich, C. Knight. "Medical and Social Responsibility in Homemaker Services", Child Welfare, Vol. 40, No. 1 (January 1961), pp. 8-11.

This article underscores the need for close working relationships among the helping professions serving individuals and families, where homemaker-home health aide service is used. The importance of understanding the "other discipline in which you are not trained" is illustrated by a few case examples. The author emphasizes that continuing evaluation of the situation in which the service is being used requires the professional judgment of both medical and social work personnel.

Bell, Grace W. and others. The Homemaker in Public Welfare. Chicago: American Public Welfare Association, 1962. 32 pp. (Out of print but available in libraries. Also available on a library loan basis from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019.)

This booklet contains four papers presented at the 1961 Biennial Round Table Conference of the Association. While several of the programs described were in their beginning developmental stages the papers give examples of what did and did not work in providing this specialized service. The papers are:

"Homemaker Service--National Developments" by Grace W. Bell
"Because Ohio Cares" by Mary Gorman
"Homemaker Services to Older People" by Annie May Pemberton
"A Homemaker Program at the Crossroads" by Doris E. Williams

Brewster, Berta M. "Extending the Range of Child Welfare Services," Children, Vol. 12, No. 4 (July-August 1965), pp. 145-150.

The author describes a homemaker service program initiated as a project in a rural county of New York. The aides were used both as mother substitutes and as home-making child-rearing teachers.

Brodsky, Rose, Kuralt, Wallace and Oettinger, Katherine. Homemaker-Home Health Services for Families with a Mentally Retarded Member. New York: National Council for Homemaker Services, 1966. 36 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00.)

Three papers, presented at the 93rd Annual Forum of the National Conference on Social Welfare held in Chicago May 29 through June 3, 1966, were published by the Council as descriptive of extended and expanded services to meet special needs of children and families. Mrs. Brodsky's paper describes a special project undertaken between two voluntary social agencies: one a specialized service for retarded children and the other an independent agency providing homemaker-home health aide service. Mrs. Oettinger's paper gives an overview of the current concerns of the Children's Bureau with services for retarded children. Mr. Kuralt's paper deals with a county public welfare department's experience in using the service to assist families in making appropriate plans for their retarded children.

Brodsky, Rose. "Philosophy and Practices in Homemaker Service", Child Welfare, Vol. 37, No. 7 (July 1958), pp. 10-14.

The author emphasizes that homemaker service "cannot stand alone as a housekeeping service" but instead is a social service. The social caseworker is presented as the co-ordinator of the service with the client, family, the homemaker, and any other helping person working with the family. The caseworker's role as a teacher-supervisor and as supportive to the homemaker is stressed.

Burford, Elizabeth and others. New Approaches to Homemaker Service. New York: Child Welfare League of America, 1964, 20 pp. Price 65 cents. (Available from the League, 44 East 23rd Street, New York, N. Y. 10010.)

This pamphlet includes reprints of four articles which appeared in the journal, Child Welfare, during 1962 and 1963. All program descriptions, the articles emphasize the need for twenty-four hour, seven-days-per-week care, the use of homemakers in a protective service and the value of a formalized training program for homemakers.

"A Formalized Homemaker Training Program" by Elizabeth Burford (September 1962)
"Nine to Twenty-four Hour Homemaker Service Project" by the staff of the Children's Aid Society, New York City (March and April 1962)
"The Team Approach in Protective Service" by Louise Foresman, Nelle Martin, Ruth Safier and Lorena Scherer (March 1963)

Burns, Mary E. and Goodman, Julia Ann. "The Teaching Homemaker in a School Project," Children, Vol. 14, No. 5 (September-October 1967), pp. 171-174.

This article describes a special project financed by the Office of Education to assist students in using educational opportunities effectively, to prevent or modify, if possible, patterns of family life that contribute to maladjustment of its families' members, particularly the socially maladjusted pupils frequently identified in the public school system as drop outs, or with failing grades. The use of homemakers as teachers to parents and pupils in their own homes is attempted and its success evaluated.

Children's Aid Society, New York City. "Nine to Twenty-four Hour Homemaker Service Project," Child Welfare Part 1, Vol. XLI, No. 3, March 1962, p.99, Part 2, Vol. XLI, No. 4, April 1962, p. 153.

This project demonstrated the use of homemaker service to avoid the placement of children in shelter care.

Children's Bureau. Homemaker Service: How It Helps Children, Children's Bureau, U. S. Department of Health, Education, and Welfare, Washington, D. C. U. S. Government Printing Office, 1967, 24 pp. Children's Bureau Publication No. 443-1967. (For sale by the Superintendent of Documents, Washington, D. C. 20402. Price 35 cents.)
Although an interpretive pamphlet, this document contains comprehensive descriptions of a variety of programs in which homemaker services are helpful to families and children. Liberally sprinkled with pictures, the document emphasizes the principles of sound foundations for a community-wide service or for an agency meeting specific needs. Case stories are also included.

Doodson, Norman. "Service for the Aged in Britain", Canadian Welfare, Vol. 4[illegible], No. 1 (January-February 1964), pp. 23-28.
This article describes the "home help" service which developed rapidly in Great Britain as the National Health Act was implemented. Approximately 55,000 "home helps" were employed by local authorities (equivalent of county departments) in 1962; and the number of elderly or chronically ill persons that year was estimated as 265,000.

"Earlham Care Program: A Small Town Organizes Basic Services for its Aging," Aging, No. 109 (November 1963), pp. 1-6.
A program in Iowa, initiated in 1963, is described in which the major features are homemaker service, handyman service, activity centers, counseling service, transportation within the community, and meals-on-wheels.

Epstein, Laura. "Casework Process in Crisis Abatement," Child Welfare, Vol. 44, No. 10 (December 1965), pp. 551.

The author describes the use of the homemaker in a treatment plan when mothers are hospitalized for psychiatric treatment, emphasizing the advantages of early decision to use the service. This experimental program was instituted at the Child and Family Service in Chicago in collaboration with the Illinois State Psychiatric Institute to serve families where the mother was hospitalized or under psychiatric care at home.

Foresman, Louise and Stringer, Elizabeth. "Homemaker Service in Neglect and Abuse: Part I, Strengthening Family Life; Part II, A Tool for Case Evaluation," Children, Vol. 12, No. 1 (January-February 1965), pp. 23, 26.

These papers were given by the authors at the 1964 National Conference on Homemaker Service in Washington, D. C. Describing the use of homemakers in helping families reported as neglecting and abusing children, the role of the homemaker as observer and teacher is shown as vital in the preventive and protective service of a public and a voluntary agency.

Goldfarb, Dora and Manko, Phyllis. "Homemaker Service in a Medical Setting," Children, Vol. 4, No. 6 (November-December 1957), pp. 213-218.

How a family agency and a hospital cooperate to give families homemaker service is related. A case story is outlined in detail to show how the plan works with the focus on the integration of homemaker service in a medical-casework setting.

Hall, Madelyn N. "Home Health Aide Services are Here to Stay," Nursing Outlook, Vol. 14, No. 6 (June 1966), p. 44.

Describes a community nursing service in Philadelphia where aides have been used as auxiliary personnel. Qualifications, job duties, priorities of assignments and something of the costs of the services are included in the content of the article.

Hart, Evelyn. Homemaker Services for Families and Individuals. Public Affairs Pamphlet No. 371. New York: Public Affairs Pamphlet, 1965. 21 pp. (Available from Public Affairs Pamphlets, 381 Park Avenue South, New York, N. Y. 10016. 24 cents.)

The text is descriptive and comprehensive of all patterns of service. General information is given plus indications of the variety and differences in method and application of this specialized service. The point is underscored that tens of thousands of homemakers are needed if adequate service is to be provided to the growing numbers of elderly, chronically ill and children.

Hicks, Florence J. "Training Neighborhood Health Aides," American Journal of Nursing, Vol. 65, No. 4 (April 1965), p. 79.

A project in Washington, D. C. to work with the "hard-to-reach" families included the use of indigenous neighborhood aides. Recruited to work under the direction of health personnel the aides were charged with the responsibility of assisting families to make full use of health facilities as both a preventive and treatment service. Health inventories were taken in families and the aides provided escort service to clinics and assisted in the home with patients cared for at home.

Hill, Esther M. "Helping Low-Income Parents Through Homemaking Consultants," Children, Vol. 10, No. 4 (July-August 1963), pp. 132-136.

In this article the service described is under the auspices of a public school district and the homemakers are employed by the school board. A part of the adult education program, these homemakers perform a teaching role, guiding parents in creating a better home life for their families. They are supervised by professional staff of the home economics education personnel. Families are referred to this special learning experience by public health nurses, county public welfare workers and housing authorities.

Hughes, Georgia P. "Homemaker Service for Migrants," Public Welfare News, Vol. 27 (December 1963). Published by the North Carolina State Board of Public Welfare, Raleigh, North Carolina.

A paper delivered at the annual Homemaker Workshop in Raleigh describes the work of a county welfare department which employs homemakers to work with crews of farm workers who come to harvest crops, bringing their families with them.

Humphrey, Jackson C. "Homemaker Service in a Psychiatric Care Program," Report on Conferences on Aging and Long-Term Care. Chicago: The American Medical Association, 1965, 105 pages. (Available from the AMA, 535 North Dearborn, Chicago, Illinois 60610 upon request.)

This article describes the experience at Evansville, Indiana State Hospital for Mentally Ill which began as a project in 1960. The homemaker service is housed with the hospital's

Social Service Department. Although a small service in numbers (36 families receiving the service) the structure, training, and coordination with other hospital personnel suggests a model for practice. The service was planned to be extended to a family for a six month period, if indicated, and most families received the service for at least four weeks.

Johnson, Nora Phillips, "Homemaker Service for Children with Psychiatric Disorders," Child Welfare, Vol. 40, No. 9 (November 1961), pp. 18-22, 29.

The author suggests that homemaker service can make a unique contribution to the treatment of emotional disturbances by placing a helping person in the child's actual living situation. The stress which family members feel, particularly an over-burdened mother, and the role which the homemaker can play as a member of the treatment team are described.

Kadushin, Alfred, "Homemaker Service," Child Welfare Services. New York: The MacMillan Company, 1967. 625 pp. (Chapter 7, pp. 275-299.)

This chapter in a standard textbook is comprehensive and descriptive of a variety of ways in which the service is used, primarily in serving families with children. It includes history, administrative aspects, case illustrations and a bibliography. The author stresses homemaker services as one of the most vital of the supplementary services, ranking it and day care along with income maintenance programs as essential in total community planning for health and welfare services.

Leedahl, Norma. "A Homemaker Speaks ..." Unpublished paper given at the 1967 North Dakota Conference of Social Welfare held in Bismark, North Dakota, on September 25, 1967.

This brief paper is a personal statement and testimony by a homemaker in a public welfare agency. The author describes the team relationship with the agency caseworkers and tells of some of her working experiences as a homemaker.

Preston, Nathalie D. "Home Economists Have Much To Contribute To Homemaker Service Programs," Journal of Home Economics, Vol. 57, No. 2 (February 1965), pp. 103-106.

Stressing the point that there is no age or physical status or economic level to which homemaker-home health aide service is limited, this article describes the way in which home economists participate in these programs. In many agencies, for example, the home economist is in charge of the agency's training course for the homemaker-home health aides.

Public Health Service, Division of Public Health Methods. Homemaker Services in the United States, 1958: Twelve Statements Describing Different Types of Homemaker Service. Washington, D. C.: U. S. Government Printing Office, 1959. 99 pp. (Out of print but available upon request to the U. S. Department of Health, Education, and Welfare, Public Health Service Washington, D. C. 20201.)

This is a compilation of reports of homemaker service programs in twelve cities prepared for use at the 1959 National Conference on Homemaker Services. Major variations in administrative patterns, as well as policies and practices, are shown.

Restad, Wesley. "A Homemaker Program to Strengthen Family Life," Public Welfare, Vol. 21, No. 3 (July 1963), p. 125.

A program is described in rural Minnesota under the auspices of a county public welfare department, with close cooperation of the county public health department.

Rice, Elizabeth P. Homemaker Service in Maternal and Child Health Programs.Washington, D. C.: U. S. Children's Bureau, 1965. Processed material, 12 pages. (Available on request from the Bureau, Washington, D. C. 20201.)

The article contains criteria for establishing a priority service for mothers and children with special needs. It was first presented at the 1964 National Conference on Homemaker Service.

Safier, Ruth. "Homemakers for Chronically Ill and Aged: A Description," The Gerontologist, Vol. 6, No. 3 (September 1966), pp. 150-153.

While this article describes the project of the St. Louis Health and Welfare Council it also points to several principles -- that of careful selection of staff, orientation, training, and supervision which stimulates growth and allows the homemaker freedom to function as a helper, using her own judgment within the framework of the agency. Case examples show the initiative and sensitivity of the homemakers.

Shames, Miriam. "Use of Homemaker Service in Families that Neglect Their Children," Social Work, Vol. 9, No. 1 (January 1964), pp. 12-18.

An experimental project carried on in the Los Angeles County Bureau of Public Assistance, financed by the U. S. Children's Bureau is described. Homemakers were assigned to twelve families (with a total of sixty-seven children) known to have been receiving public assistance for many years and to have serious problems of neglect and deprivation. Although none of the families had responded to the efforts of the social workers toward improving their standards of child care and household management they made positive gains which persisted even six months beyond the discontinuance of the homemaker service. The report suggests that starting families in the direction of rehabilitation is one of the most challenging tasks of a homemaker service.

Stringer, Elizabeth A. "Homemaker Service to the Single-Parent Family," Social Casework, Vol. 48, No. 2 (February 1967), pp. 75-79.

An organized homemaker service program in New York is described which gives high priority to serving children who otherwise would require placement in foster care, including children of unmarried mothers. The service is provided during a crisis period to help keep the home intact for periods from a few days to several months.

Trager, Brahna. "The Use of Homemaker Service in Preserving Family Life," Unpublished paper presented at the Minnesota Welfare Association Annual Conference, St. Paul, Minnesota, March 16, 1965. (Mimeographed.)

Preventing hasty placement of children at times of family crisis, maintaining stability when mothers are hospitalized or are otherwise absent, and assisting mothers who know little about childcare and household management are described as equally valid uses of homemaker-home health aide staff members. The author cautions against the expectation that the teaching homemaker can "preserve" an unhealthy family situation or miraculously make it healthy.

Williams, Johnnie U. "The Caseworker-Homemaker Team," Public Welfare, Vol. 23, No. 4 (October 1965), p. 275. (Reprints available from Social and Rehabilitation Service, U. S. Department of Health, Education, and Welfare, Washington, D. C. 20201.)

Emphasis in this article is placed on the team relationships for diagnosis and treatment, and in raising the levels of living of families disorganized by multiple problems along with poverty.

Winston, Ellen. "Current Realities and Future Opportunities for Homemaker-Home Health Aide Services." Paper given at the Annual Meeting and Forum of the National Council for Homemaker Services held May 4, 1967, in New York. (Available from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019.)

The author stresses the nature of this specialized service as a "family service" which includes the single adult living alone. The use of homemakers in situations where children are neglected and even abused and the levels of living are inadequate for healthy, normal family life are described. Support and consultation from Federal sources are explained.

Winston, Ellen. "Homemakers, A National Need". Paper presented at the National Conference on Homemaker Services, Washington, D. C., on April 29, 1964. (Available from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019.)

Stating the problem of "the acute and pressing need for expansion of homemaker service throughout the United States," the author views the service as one of the most effective ways of counteracting the effects of poverty. How it can achieve that goal is dependent upon responsible fiscal and administrative measures which will assure sufficient numbers of staff to maintain continuity of the service and its availability to all who need it.

Wolff, Myrtle P. "Surmounting the Hurdles to Homemaker Services," Children, Vol. 6, No. 1 (January-February 1959), pp. 17-22.

Eight years of experimentation and programming for homemaker services to families with children in both urban and rural areas of North Carolina proved to the State Department of Public Welfare that this service has special values in preserving family life. Some of the results are described in this article.

Yaguda, Mrs. Asher. "Homemaker-Home Health Aide -- A Unified Service," Highlights -- 1967 Annual Meeting and Forum. New York: National Council for Homemaker Services, 1967. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. Fifty cents.)

Terminology used in the 1965 amendments to the Social Security Act with regard to medical care and payment of treatment for eligible patients in their own homes caused confusion in the planning for, and use of, "health aides" and "homemaking aides." The author emphasizes that the aides have the same training and perform the same functions under professional supervision, sometimes a public health nurse and sometimes a social worker.

HOME CARE PROGRAMS

The following references are listed regarding home care programs since there is considerable use made of homemaker-home health aides in such programs. Also, because of the similarity of the terms used there is often confusion that a "home care" program is the same as "homemaker services," or that it encompasses the homemaker-home health aide service. Frequently a coordinated or comprehensive home care program employs its own homemaker-home health aide staff, but also such programs may purchase the homemaker-home health aide service from the agency operating such a service in a given community.

Browning, Francis E. "Organizational Patterns for Coordinated Home Care Programs," Homemaker-Home Health Aide Service in Home Care Programs. New York: National Council for Homemaker Services, Inc., 1967, 43 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00)

One of a group of papers presented at the 94th Annual Forum of the National Conference on Social Welfare in Dallas, Texas, May 21-26, 1967, in a session co-sponsored by the American Medical Association, American Hospital Association and National Council for Homemaker Services. This paper points out the lag in the development of this needed service as being due to confusion and profusion of terminology and auspices, failure to identify the program with patient needs, and the lack of money and qualified health-services personnel.

Grant, Murray. "Health Aides Add New Dimension to Home-Care Programs," in Hospitals, Vol. 40, December 1, 1966, pp. 63-67.

In this journal published by the American Hospital Association the article describes the function of the home health aide, how aides are recruited, trained, and utilized. The strategic role they play in contributing to the success of the home care program is underscored. The author explores the need for home care programs, outlining the background and development of such a service in the District of Columbia.

Lester, Eileen E. "Home Care Programs Meet Community Need," Homemaker-Home Health Aide Service in Home Care Programs. New York: National Council for Homemaker Services, Inc. 1967. 43 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00)

This article identifies the contribution of social workers and homemaker-home health aides in coordinated home care programs usually operated under medical auspices. It also gives some statistical data regarding the expansion of home care programs since 1965 legislation.

Public Health Service, Division of Medical Care Administration. The Physician and Home Care -- Case Studies and Commentary. Washington, D. C.: U. S. Department of Health, Education, and Welfare. 1967. (Available from the Department, Washington, D. C. 20201.)

This is a kit composed of seven pamphlets and reprints of two articles, including a 1966 AMA Staff Task Force report on Home Care. It contains guides for developing and administering coordinated home care programs. These materials emphasize that leadership by physicians is essential to efficient and successful provision of home care services.

Smith, Lucille M. and others. Let's Understand Home Care. Chicago: American Public Welfare Association, 1964. 33 pp. (Out of print, but available in libraries of schools and public health and welfare agency libraries; also available on library loan from National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019.)

Four papers presented at conferences on public welfare programs and problems, sponsored by the Association, make up the content of this booklet. The basic element of a home care program is that it is a physician-directed program, whether hospital-based, agency-based, or community-based. Early discharge of patients from hospitals, and treatment for patients to prevent hospitalization are viewed as the goal of the home care program team. The role of the homemaker-home health aide as a member of the treatment team is described in two of the papers.

"Introduction" by Edwin R. Conners
"Organized Home Care, Community Based" by Lucille M. Smith
"Hospital-based Home Care, Programs" by Peter Rogatz
"Home Care Administered by a Visiting Nurse Association" by Sylvia R. Peabody
"Home Health ServicesCare" by Alice K. DeBenneville

Winston, Ellen. "Health-Welfare Partnership in Programs for Low Income Groups", in American Journal of Public Health, Vol. 57, No. 7 (July 1967) pp. 1100.

The article includes factual data re: low incomes among segments of the population, outlines the five specific services which Title XIX of the 1965 Social Security Amendments will provide by July 1, 1967, through certified agencies and institutions. A plea is made for a true partnership relationship between health and welfare personnel and institutions, stressing the case finding and case follow-up which will be necessary if Title XIX programs are to be utilized by all who need them.

Winston, Ellen. New Opportunities for Medical Services. Washington, D. C.: U.S. Department of Health, Education, and Welfare (Available upon request from the Department, Washington, D. C. 20201.)

This small pamphlet is a reprint of a paper presented by Dr. Winston before the Women's Auxiliary to the American Medical Association's Annual Conference held in Chicago, Illinois, October 3, 1966. The author gives factual data regarding the numbers of states which had implemented Title XIX programs by that date. It describes the range and scope of the program as intended by the Congress. The benefits to different client groups such as children under 21 years of age found to be "medically needy" and the "medically indigent" are explained. Some tasks of the homemaker-home health aide are described.

STANDARDS AND PRINCIPLES

CWLA Standards for Homemaker Service for Children, Committee on Standards for Homemaker Service. New York: Child Welfare League of America, 1959. 45 pp. (Available from the League, 44 East 23rd Street, New York, N. Y. 10010. $1.25)

This document is coded numerically for quick reference use so that sub-headings can be located in relation to chapter headings which are: homemaker service as a child welfare service, the role and development of the homemaker, the caseworker in homemaker service, organization and administration of the service, and community planning for homemaker service. The pamphlet includes a selected reading reference list and is indexed.

Guidelines for the Development and Utilization of Home Health Services in the Community. Committee on Practice and Executive Committee, Division on Community Health Nursing Practice, American Nurses' Association. New York: the Association, 1967. 34 pp. (Available from the Association, 10 Columbus Circle, New York, N. Y. 10019. $1.00)

The focus of this booklet is that of the public health nurse and personnel who may be employed to assist and to be supportive of public health nursing service. These guidelines were prepared as a supplement to an earlier publication titled "A Guide for the Utilization of Personnel Supportive of Public Health Nursing Services" published in 1966. The appendix contains some excerpts from the 1966 booklet, and a selected reading reference list.

Standards for Homemaker-Home Health Aide Services, Committee on Standards. New York: National Council for Homemaker Services, 1965. 45 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.00)

This document was developed by a committee representative nationally of health and welfare agencies providing homemaker-home health aide services, and governmental units of the U.S. Department of Health, Education, and Welfare. Under the auspices of the national organization incorporated for the purpose of stimulating the expansion and promoting the improvement of homemaker services throughout the country, this first edition of the standards is being widely used. It uses a simple coding system, but is not indexed to the code. The pamphlet includes a brief bibliography. As a definitive statement of the National Council for Homemaker Services this document is subject to review and updating periodically.

TRAINING OF THE HOMEMAKER-HOME HEALTH AIDE

Burford, Elizabeth. "A Formalized Homemaker Training Program" in "News from Field", Child Welfare, Vol. 41, No. 7, (September 1962), pp. 313-317.

The training program described in this article includes a course given under the auspices of a graduate school of social work. It reflects the philosophy, method and content of training given to homemakers on the staff of the Child and Family Services Agency of Chicago.

Carey, Ione. "Training and Use of Home Health Aides", American Journal of Nursing, Vol. 65, No. 4 (April 1965), pp. 1771-74.

The author emphasizes the need for training and supervision of an "unlicensed, nonprofessional worker" who will not substitute for the services of a nurse but will work under the supervision and guidance of a professional nurse. The article makes reference to the national shortage of nurses, and recommends expanding the use of auxiliary personnel such as home health aides.

Homemaker-Home Health Aides -- Training Manual. Prepared by the National Council for Homemaker Services under the auspices of the Office of Education, U.S. Department of Health, Education, and Welfare. New York: The Council, 1967. 181 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. Members, $3.00; non-members, $5.00)

This document is the training guide developed and recommended by the national organization for this specialized field of service. It is described as a working tool and a resource guide for administrators, supervisors, and teachers concerned with planning and developing training programs -- both pre-service and on-the-job training -- for homemaker-home health aides. A practical how-to-do it manual, it contains ten units of instruction with teaching resources and suggested learning experiences geared to the educational objectives of each unit.

Lefson, Eleanor E. "One Week's Training for the Home Health Aide", Nursing Outlook, Vol. 14, No. 6 (June 1966), pp. 48-50.

This article is written from the viewpoint of a public health nurse. Aides are trained in certain technical skills in nutrition and "rehabilitative therapy." The author points out the necessity for training and the expectations held for the aides who will contribute as team members to the care of the chronically ill and others cared for in their own homes. The schedules of classes and field experience for the week is included. In teaching this course the professional nurse instructors were reported to have awakened to a new sense of values in understanding human relationships.

Trager, Brahna. "Recruitment and Training of Homemaker-Home Health Aides". Unpublished paper presented at the Workshop on Administering and Financing Home Care Programs, University of Michigan, School of Public Health, Ann Arbor, Michigan, March 22-26, 1965. (Mimeographed.)

The focus of this paper is on the training content for homemaker-home health aides and the inescapable responsibility for training which falls on the agency administering the service. The author also stresses adequate financing of such a program for the benefit of all who give and use the service.

Trager, Brahna. Training Homemaker-Home Health Aides for Community Service. Washington, D. C.: General Service Administration, 1967. 142 pp.

This training guide was developed under the auspices of the Office of Economic Opportunity, Community Action Program and the U.S. Department of Health, Education, and Welfare, Public Health Service. It is intended for the use of teachers in health and welfare agencies developing training programs for homemaker-home health aides. The format is narrative style with chapters and subheadings. It includes a sample training outline and a selected reading list.

TEACHING METHODOLOGY

Corsini, R. J. and Howard, D. D., (Editors). Critical Incidents in Teaching. Englewood Cliffs, New Jersey: Prentice Hall, Inc., 1964. 222 pp.

This book is a compilation of critical incidents used as illustrative materials for teaching in professional schools. It is designed to assist teachers in developing techniques for stimulating problem-solving discussions.

Oswald, Ida. *An Annotated Bibliography on Audiovisual Instruction in Professional Education.* New York: Council on Social Work Education, 1966. 61 pp.

References are grouped in three sections on social work literature, literature from related professional fields and general references. This document was produced to stimulate the interest of professional schools' teaching staff in the use of audiovisual aids. It suggests that new teaching media opens fresh approaches, bringing current and emerging practice into the class room and increasing the realism of instruction.

Swell, Lila. "Learning Theory and the Use of Role Playing in Casework Teaching", *Journal of Education for Social Work*, Vol. 4, No. 1 (Spring of 1968).

The author, an associate professor in a graduate school of social work, describes some class room experiences with role playing and the conscious use of learning theory in developing role playing opportunities for students.

The Teacher's Compendium, compiled and edited by Marguerite V. Pohek. New York: Council on Social Work Education, 1963. 72 pp.